COVID-19 Patient Disclosure and Consent Form

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus. It is important that you disclose to this office any indication of having been exposed to COVID-19, or if you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you currently have a fever or above normal temperature?	☐	☐
Have you had a fever in the past 72 hours?	☐	☐
Have you experienced shortness or breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Have you recently lost or had a reduction in your sense or taste or smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐

I, _____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have a risk of contracting the virus by being in a dental office.

Signature_____ Date_____