DENTAL HEALTH ASSOCIATES
dhamadison.com

COVID-19 Virus Dental Treatment Consent Form

Dental Health Associates (DHA) cares about not only your oral health but also your well-being. It is important to understand the risks of contracting or transmitting the COVID-19 virus in seeking dental care. We ask you read this carefully before signing. By signing, you are acknowledging that you understand the risks and do desire to receive your dental care today.

I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. DHA has implemented protocols including temperature checks for patients and staff, but these protocols will not identify asymptomatic carriers of COVID-19 virus.

I understand that the CDC recommends social distancing of at least six (6) feet and that this social distancing recommendation is not possible during dental procedures

I understand that due to the frequency of visits of other dental patients, the treatment by DHA providers, the characteristics of the virus, and the characteristics of dental procedures, that there is risk of transmission.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- ☐ Fever
- ☐ Dry Cough
- ☐ Sore Throat
- ☐ Shortness of Breath
- ☐ Malaise (a general feeling of discomfort or illness)
- ☐ Headache
- ☐ Chills
- ☐ Loss of Sense of Taste or Smell

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus and verify that I have not traveled outside of the United States, nor have I traveled domestically within the United States by commercial airline within in the past fourteen (14) days.

This informed consent has been explained to me in a language I understand. I was given enough time to read this informed consent and to decide for or against this dental treatment. I have been told that if I have any questions about the screening process or the policy, they will be answered.

_____ _____

Patient/Authorized Representative Signature Date

_____

Patient/Authorized Representative Printed Name