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**COVID-19 (Coronavirus) Pandemic Dental Treatment Consent Form**

**Rather than having our patients who frequently visit the office sign this form each time, we want to be considerate of your time.** By signing this document, I agree to complete this form and to advise Dr. Utermark of any changes or COVID exposures as Dr. Utermark really wants to protect her staff and patients. _____ (Initial)

**I confirm that I / my child are not presenting with any symptoms of COVID-19 including the following:**
- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- _____ (Initial)

- I have not been in contact with someone who has been sick with these symptoms, is being tested or in quarantine with suspected COVID-19, is caring for a person with COVID-19 or has tested positive for COVID-19 _____(Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____ (Initial)

- I verify that I /my child have not traveled outside the United States in the past 14 days. _____(Initial)
- I verify that I / my child have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____(Initial)

**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.

There are several modes of transmission of COVID-19 which could be present in a dental office. We are following the ADA and CDC guidelines to minimize the risk of transmission.
- 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 an elevated risk of contracting the virus simply by being in a dental office. _____ (Initial)

Printed Name of Patient: _____ Birth Date: _____

Signature of Patient/Parent/Guardian of a minor_____ Today's Date _____

Printed Name of Parent / Guardian_____