# COVID-19 Request for Treatment Consent & Representations

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I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes my dentist's office. I have been informed by my dentist of his desire to protect their patients, staff, and the community at large. WE ARE TAKING EVERY PRECAUTION NECESSARY TO LIMIT THE EXPOSURE OF ANY VIRUS WITHIN OUR OFFICE.

*I understand that despite my health care provider's best efforts to identify potential carriers of the virus, we cannot guarantee that we are able to identify such individuals and prevent them from potentially bringing the virus to this office. Despite safeguards instituted to minimize infection, I understand that there is a risk that performing this procedure, and the care associated with it, may result in my becoming infected with the COVID-19 virus. Such infection could further result in significant sickness, disability, or death.*

I understand that in addition to this Special Consent Form for An Elective Surgery or Procedure During the COVID-19 Pandemic, I will be provided a separate Consent Form for review regarding a particular surgery or procedure to be performed. I understand that this Special Consent Form is only being used because of the unique circumstances surrounding the pandemic.

**As a prerequisite to obtaining the treatment proposed, I am confirming that I have none of the current commonly known COVID-19 symptoms now or in the past 14-21 days:**

- **fever/feeling hot or feverish**
- **cough**
- **shortness of breath/difficulty breathing**
- **sore throat**
- **loss of taste &/or smell sensation**

**I confirm that I have not traveled by airplane, cruise ship, train or other form of public transportation in the past 14-21 days.**

**I confirm that I have been practicing all current CDC guidelines with respect to "social distancing" and I have NOT been in contact with any person who had a positive test for COVID-19 OR was suspected to be positive (OR have been in contact with someone who has been in contact with a positive or suspected COVID-19 person).**

I hereby consent to the treatment proposed by my dentist.

Name: _____

Signature: _____

Date:_____