COVID-19 PANDEMIC DENTAL TREATMENT
Consent Form

Patient Date of Birth (MM/DD/YYY): _____

I, **(Patient Name)**, _____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I consent to have my body temperature taken. _____ **(Initial)**

Temperature: _____ (**We will fill out temp for you once seated in the treatment room)**
(Must be below 100.4 to be treated in this dental facility.)

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. Dental procedures create water spray, which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus. _____ **(Initial)**

I understand that due to the visits of other patients, the characteristics of the virus, and the characteristics of the dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____ **(Initial)**

I confirm that in the last month, I, or a close contact ***do not*** have the following symptoms of COVID-19 listed below:

- Fever, shortness of breath, headache, sore throat, chills, muscle aches, new loss of taste or smell, diarrhea. _____ **(Initial)**

I confirm that a close contact or I have ***not*** taken antibiotics or medicine for fever. _____ **(Initial)**

I confirm that a close contact or I have ***not*** traveled outside of Hawaii/Maui in the last 14 days. _____ **(Initial)**

I confirm that a close contact or I did ***not*** have recent testing for COVID-19 with or without a result available. _____ **(Initial)**

I confirm that a close contact or I have ***not*** been to the hospital within the last 2 weeks. _____ **(Initial)**

I verify that I have ***not*** had close contact with anyone diagnosed with COVID-19. _____ **(Initial)**

Printed Name of Patient/Guardian: _____

Patient/Guardian Signature: _____ **Date:** _____

Staff Signature: _____