

COVID-19 Pandemic Emergency Dental Treatment Consent Form

I, _____ knowingly and willingly consent to having 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. Given the current limits in virus testing, it is impossible to determine who has it and who does not have COVID-19.

Dental procedures create water spray (aerosols), which is one way the disease can be spread. The ultra-fine nature of the spray can linger in the air for several minutes to hours, which can transmit the COVID-19 virus.

- 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)

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

- Fever
- Shortness of breath
- Cough
- Stomach upset
- Sore throat

_____ (Initial)

I understand that air travel significantly increases the 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 around anyone who has traveled by air, and this distance is not possible with dentistry. _____ (Initial)

- I verify that I have not traveled outside the United States during the past 14 days to countries that have been affected by COVID-19. _____ (Initial)

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

Name _____

Date _____

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient) _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (if different from patient) _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Please complete both sides.