Dental Treatment Consent Form
COVID-19 Pandemic

1. I knowingly and willingly consent to dental treatment at_____ by Dr. _____ and any designated associates and employees during the COVID-19 pandemic.

2. I understand that Dr._____ is following CDC guidelines and a mandate by the Utah Department of Health effective March 25, 2020 restricting nonessential dental procedures. I have been given an explanation why the procedures recommended for me to undergo fall under urgent care or emergency procedures. I understand that dental visits are therefore limited to the treatment of pain, infection, and other conditions that significantly inhibit normal operation of teeth and mouth or could be detrimental to overall health and are thus considered urgent or emergent, and issues that could be detrimental to overall dental and physical health if not treated within the next several months. I confirm that I am seeking treatment for a condition that qualifies and requires essential, emergent or urgent care.

3. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has it and who does not given the current limitations and availability in COVID-19 viral testing. I understand that emergency or urgent dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the spray can linger in the air for hours, which can transmit the COVID-19 virus.

4. Risk of transmission: I understand that due to the frequency of visits of other emergency or urgent care dental patients, 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, even though CDC and Utah Department of Health mandates are being observed.

5. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
    A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celcius or higher
    B. Shortness of breath
    C. Dry cough
    D. Runny nose
    E. Sore throat.
    F. Diminished sense of taste and smell

6. Contact with infected: I confirm that I have not knowingly been in close contact defined as 6 feet or less for a duration of fifteen minutes or more with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in the last 14 days.

7. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ _____ _____

Patient's name (please print) Signature of patient, legal guardian or authorized representative Date

_____ _____

Witness to signature Date