**Erskine Family Dentistry**

# COVID-19 Treatment Consent Form

I, (the patient), consent to receive treatment from Erskine Family Dentistry during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

I understand that the symptoms listed below are representative of COVID-19:

* Fever
* Dry Cough
* Shortness of Breath
* Temperature
* Persistent pain or pressure in the chest
* Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above: (Initial)

I understand that all travelers arriving from a country or region with [widespread ongoing transmission, as outlined by the CDC,](https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html) should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission

[(Level 3 Travel Health Notice)](https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html) in the past 14 days. (Initial)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. (Initial)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_