**Top of Form**

**COVID-19 Dental Treatment Consent Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

Do you have a fever, or have felt hot or feverish anytime in the last two weeks?

 Yes

 No

Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip? Loss of taste and/or smell?

 Yes

 No

If you answered yes to any of the questions above but are not sick, please state why: (example: allergies, chronic cough, asthma etc)  
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Are you over the age of 70 or considered high risk?

 Yes

 No

IF YES; you confirm that you understand high risk for severe COVID-19 includes those with pre-existing conditions such as: serious respiratory disease, serious heart conditions, immunocompromised conditions, severe obesity, diabetes, chronic kidney disease, or those underdoing dialysis, and liver disease, as well as patients that are pregnant.

 Yes

 No

Signature Of Patient or Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Bottom of Form