MAIN STREET DENTAL
your main address for gentle convenient care

Informed Consent for Dental Treatment in the Era of COVID-19

I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any public place, which includes the dental office. Be assured that we are taking every precaution necessary to limit the exposure of any virus within our office.

I understand that despite my healthcare providers best efforts to identify potential carriers of the virus, we cannot guarantee that we are able to identify such individuals and prevent them from bringing the virus into our office. Despite safeguards instituted to minimize infection, I understand that there is a risk that performing this procedure, and the care associated with it, may result in my becoming infected with the COVID-19 virus. Such infection could further result in significant sickness, disability, or death.

As a prerequisite to obtaining the treatment proposed, I am confirming that I have none of the commonly known symptoms of COVID-19 (fever, cough, shortness of breath, sore throat, loss of taste and/or smell sensation) and that I have not recently traveled by airplane. Further, I have been practicing current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

I hereby consent to the treatment proposed by my dentist

Yes _____ No _____

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian's Signature Date

_____
Dr. Signature