

COVID-19 Treatment Consent Form

I, _____, consent to receive emergency treatment from Smile Artistry 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 COVID-19, 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](#), 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 transmissions ([Level 3 Travel Health Notice](#)) 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: _____

For Practice Use:

Doctor Signature: _____

Date: _____