THE DENTAL FAMILY COVID FORM

- ❏ I consent to receive treatment from The Dental Family during the COVID-19 outbreak.
- ❏ I understand there is much to learn about the newly emerged COVID-19, including how it spreads and is 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 during close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a 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, and by receiving treatment at, the Practice.
- ❏ I understand that even with the Practice following all the CDC and ADA guidelines for infection control of COVID-19 in providing dental treatments, that I am still at risk for possible infection with receiving such treatment at the Practice at this time.

Do you have a cough? **YES OR NO**

Do you have a fever or have you had one in the past 14 -21 days? **YES OR NO**

Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days? **YES OR NO**

Are you experiencing other flu-like symptoms such as GI upset, headaches or fatigue? **YES OR NO**

Have you experienced recent loss of taste or smell? **YES OR NO**

Do you have heart, lung, or kidney disease, diabetes, or any auto-immune disorders? **YES OR NO**

Have you traveled in the past 14 days to any regions COVID affected other than your surrounding area? **YES OR NO**

- ❏ I release, that is, I give up and forever relinquish any and all claims, complaints and any legal actions in any court of law, or in any other proceedings before any governmental entity, should I become infected with the coronavirus, or should I suffer any other personal, physical or other injury from coronavirus as a result of the dental treatment I have received from the Practice and from all the professional and technical providers who treat me at the Practice. I understand this release means that I can never bring any claim for money damages, nor any other legal remedy/relief against the Practice and any of the professional and technical providers at the Practice due to coronavirus.

- ❏ I acknowledge that I have read and understand this Release and that I knowingly and voluntarily have signed it as a condition of the Practice agreeing to provide treatment for me

Name _____

Date _____

Signature of patient or guardian _____