COVID-19 ACKNOWLEDGEMENT OF RISK FORM

Date:
Patient:
DOB:

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

This virus is a highly contagious disease. The WHO has classified it as a pandemic. You can contract the disease from a variety of sources and our practice wants to ensure you are aware of any additional risks associated with dental care.
The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show any symptoms and yet still be highly contagious. Determining who is infected is challenging and complicated due to limited availability for testing.
Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus. Some dental procedures result in the production of aerosols which is one way the disease is spread.
Our office adheres to the guidance set forth by the CDC and OSHA, following universal precautions and several other measures in order to provide the our patients and staff the safest environment we can, based on the current research. Pre-visit phone assessment, additional current health form, taking of temperatures before any treatment and new barrier protections are just a few of the additional precautions our office has instituted at this time. Since you could contract this disease anywhere, we respectfully ask that you contact us if you should experience any COVID-like symptoms within 14 days of your visit

I confirm that I have read this notice and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office. I also acknowledge that I could contract the COVID-19 virus from outside this office unrelated to a dental appointment and agree to notify this office if I experience any disease symptoms within 14 days of my most recent visit.

I have read and understand the information stated above.

_____ _____

Patient Signature Date