

COVID-19 Treatment Consent and Release of Claims Form

I, _____ (the patient),

Print name

consent to receive dental treatment from Penny Creek Family & Implant Dentistry, Dr. Chad Slocum or Dr. Sara Lundgaard during the COVID-19 Pandemic.

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, Penny Creek Family & Implant Dentistry.

I understand that even with the Practice following all the CDC and ADA guidelines for infection control of COVID-19 in providing dental treatment, that I am still at risk for possible infection with receiving such treatment at the Practice at this time. _____(Initial)

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
- Cough
- Shortness of Breath
- Chills
- Repeated Shaking
- Fatigue
- Muscle Aches
- Vomiting
- Headache
- Sore Throat
- New Loss of Taste or Smell
- Malaise
- Nausea
- Diarrhea

I confirm that I, and those who live with me, have not displayed, or currently have, any of the symptoms that are representative of COVID-19, which are outlined above. _____(Initial)

I confirm that, to the best of my knowledge, in the past 14 days I have not come into close contact with anyone who appeared to me as displaying, or having, any of the symptoms that are representative of COVID-19, which are outlined above. _____(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)

I understand that all travelers arriving from a country or region with widespread ongoing transmissions should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I, and those who live with me, have not returned in the last 14 days from traveling to any of the countries or regions with widespread ongoing transmissions, including all European countries, China, Korea, and Latin America. _____(Initial)

