



## **COVID-19 PANDEMIC TREATMENT**

### **CONSENT FORM**

I, \_\_\_\_\_, knowingly and willingly consent to have treatment completed during the COVID-19 pandemic at Dent Lounge.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

- I understand that due to the frequency of visits of other patients, the characteristics of the virus, and the characteristics of potential procedures, that I have an elevated risk of contracting the virus simply by being in a medical or dental office. \_\_\_\_\_ (**initials**)
- I have been made aware of the CDC guidelines that under the current pandemic all non-urgent care is not recommended. \_\_\_\_\_ (**initials**)
- I confirm that I am NOT presenting with any of the following symptoms of COVID-19 listed below. \_\_\_\_\_ (**initials**)
  - FEVER
  - SHORTNESS OF BREATH
  - DRY COUGH
  - RUNNY NOSE
  - SORE THROAT
  - SNEEZING, WATERY EYES, OR SINUS PAIN OR PRESSURE UNRELATED TO SEASONAL ALLERGIES
  - HEADACHES, FATIGUE, OR WEAKNESS
  - LOSS OF SENSE OF TASTE OR SMELL

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. I also understand that the CDC recommends social distancing of at least 6 feet and that this will NOT be possible with my treatment today. \_\_\_\_\_ (**initials**)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. \_\_\_\_\_ (**initials**)
- I verify that I have not traveled domestically with the United States by commercial airline, bus, or train within the past 14 days. \_\_\_\_\_ (**initials**)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Temperature \_\_\_\_\_