

COVID-19 (Coronavirus) Disclosure/Consent

Patient Name: _____

The Centers for Disease Control and Prevention (CDC), the American Dental Association (ADA), and the state dental board have all issued a strong recommendation to postpone any non-emergent dental care until further notice during the COVID-19 pandemic.

Current studies indicate that some dental procedures create aerosolized particles (similar to a sneeze), which can linger in the air for minutes to sometimes hours, which can result in transmission of COVID-19.

I understand and acknowledge these recommendations and hereby declare that I have an emergent or urgent dental condition that requires prompt care (or I have a child with an emergent or urgent dental condition). _____ (Initial)

I hereby affirm that my dentist/surgeon and anesthesiologist have offered me the opportunity to reschedule dental treatment under general anesthesia to a subsequent date pending recommendation changes. _____ (Initial)

I also affirm that I have freely elected to proceed with the procedure due to pain/infection that are unmanageable at home with medications. I have consulted the treating dentist for other alternatives. _____ (Initial)

I fully understand that proceeding with the treatment today increases my exposure/my child's exposure and therefore risk of contracting community acquired COVID-19 (Coronavirus) infection. Acquiring such infection can lead to symptoms such as fever, chest pain, shortness of breath and further respiratory complications. Severe disease can also lead to: prolonged hospitalization, intensive care admission, mechanical ventilation, and/or possible death.

I also affirm that neither I/my child, nor any of my family members have been exposed to or had any of the following symptoms in the past 14 days:

- 1) Fever ($\geq 100.4^{\circ}$ F)
- 2) Shortness of breath
- 3) Dry cough
- 4) Fatigue and body aching
- 5) Chest pain
- 6) Confirmed or suspected COVID-19 (Coronavirus) infection

I am consenting to this procedure with full understanding and disclosure of such risks and alternatives, and all my questions were answered to my satisfaction.

Name (printed): _____

Signature: _____

Relationship to patient (if applicable): _____

Date: _____