MIDLAND PARK
FAMILY DENTISTRY, LLC

COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

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 difficult to determine who has it and who does not given the current limits in the virus testing. I give my consent for treatment during this time.

PLEASE SELECT APPROPRIATE RESPONSE TO THE FOLLOWING QUESTIONS

	YES	NO
ARE YOU CURRENTLY AWAITING RESULTS OF A COVID-19 TEST?	◯	◯
DO YOU HAVE A FEVER?	◯	◯
DO YOU HAVE ANY SHORTNESS OF BREATH?	◯	◯
DO YOU HAVE A COUGH?	◯	◯
DO YOU HAVE CONGESTION OR RUNNY NOSE UNRELATED TO SEASONAL ALLERGIES?	◯	◯
DO YOU HAVE A SORE THROAT UNRELATED TO SEASONAL ALLERGIES?	◯	◯
ARE YOU EXPERIENCING HEADACHE, FATIGUE OR MUSCLE ACHES?	◯	◯
HAVE YOU LOST YOUR SENSE OF TASTE OR SMELL?	◯	◯
HAVE YOU TRAVELED TO ANY FOREIGN COUNTRY WITHIN THE LAST 14 DAYS?	◯	◯
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELED WITHIN THE UNITED STATES?	◯	◯

IF SO, WHERE? _____

By signing this document, I acknowledge the answers I have provided above are true and accurate.

_____

Patient/Responsible Party Signature Date