

Informed Consent for Receiving Dental Treatment During the COVID-19 Pandemic

«Patient Full Name»

«Current Date: Month Day, Year»

I understand that I have come to Dr. Nicoara's office for periodontal care that will be performed during the COVID-19 pandemic. I have been advised of the following:

While this office complies with Washington State Department of Health guidelines, and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, this office cannot make any guarantees.

The staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since this is a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, I understand that I will be asked a number of "screening" questions relating to coronavirus symptoms or activities at high risk for coronavirus infection. For the safety of our staff, other patients, and myself, I agree to be truthful and candid in my answers.

Signature of Patient

Signature of Parent (if Patient is a Minor)

Signature of Witness