HOMESTEAD DENTAL COVID-19 INFORMED CONSENT

Dental Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedure we provide, it is not possible to maintain social distancing between the patient, dentist, dental staff and sometimes other patients at all times.

Although exposure is highly unlikely, by signing this consent form you accept the risk and consent to treatment.

______________________________________ ______________

Patient/Parent's Signature Date

PATIENT COVID-19 SCREENING

Patient name:______________________________ **time and date:**_____________________

If patient is a minor, name of parent or guardian answering:_________________________

Screener name:_____________________________

Yes No Do you have a fever or abnormal temperature?
Yes No Have experienced shortness of breath or have had trouble breathing?
Yes No Do you have a dry cough?
Yes No Do you have a runny nose?
Yes No Loss taste or smell?
Yes No Do you have a sore throat?
Yes No I don't know Have you been in contact with someone that has tested for COVID-19?

Do any of these apply to the patient?
Yes No Moderate to severe asthma or chronic lung disease
Yes No Cancer treatment or medicines causing immune suppression
Yes No Inherited immune system deficiencies or HIV
Yes No Serious heart conditions, such as heart failure or prior heart attack
Yes No Diabetes with complications
Yes No Kidney failure that needs dialysis
Yes No Cirrhosis of the liver
Yes No Diseases or conditions that make it harder to cough
Yes No Extreme obesity
Yes No Pregnancy
Yes No Have you been tested for COVID-19 and have tested positive or are waiting results?
Yes No In the last 14 days, have you traveled internationally?
Yes No Have you traveled within the U.S. by air, bus, or train within the past 14 days?

Yes No Have any of these answers changed since the questionnaire screening was given?

Temperature reading: _______________________

Patient or guardian signature:________________________________ **date:**_______________