



**Dental Treatment Consent and Affirmation Form for
COVID-19 Pandemic**

1. I knowingly and willingly consent to dental treatment at Urgent Dental of Denver
2. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has COVID-19 and who does not given the current limitations and availability in COVID-19 viral testing.
3. Risk of transmission: I understand that due to the frequency of visits of other care dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though standard precautions are being observed.
4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
 - A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher
 - B. Shortness of breath
 - C. Dry cough
 - D. Runny nose
 - E. Sore throat.
 - F. Diminished sense of taste or smell
5. Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in paragraph 4 (#4) in the last 14 days.
6. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

Patient's name (please print)

Signature of patient, guardian or authorized representative

Witness to signature

Date

COVID-19 HEALTH SCREENING FORM - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19? If yes , what was the date? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested positive for COVID-19? If yes , what date did you test positive? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19 and are awaiting results?	<input type="checkbox"/>	<input type="checkbox"/>
If you have COVID-19, how long have you been free of symptoms?	Provide Date: _____	
Have you traveled outside the United States by air or cruise ship in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled within the United States by air, bus or train within the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

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

Print Patient Name

Patient Signature (parent if minor)

Date

Witness