COVID-19 (Coronavirus) Informed Consent for Dental Care and X-Ray

Patient's Name: ________________________ Cell#: ________________________

You have the right to accept or refuse dental treatment recommended by your dental provider When a procedure or treatment requires your specific written informed consent, your dental treatment provider will have a conversation with you to describe the risks and benefits of recommended treatment, reasonable alternatives and their risks and benefits, and the risks of not pursuing the recommended treatment. You will also be required to sign an informed consent to treatment form documenting that discussion and the information you received in order to make an informed decision to accept or refuse dental care.

You understand and acknowledge that you are seeking dental treatment for essential dental care during the COVID-19 pandemic. In order to receive this treatment, your dental provider will perform infectious disease screening and may not be able to provide dental treatment if you are exhibiting symptoms consistent with COVID-19.

You confirm the following with respect to this patient screening, please check all that apply:

- ☐ A dental staff representative took my temperature, and it was __________ Office staff initials: ______
- ☐ I am not exhibiting signs of acute respiratory illness such as coughing, fever and shortness of breath.
- ☐ Neither I nor anyone in my immediate family/contact circle has had a positive Covid-19 test or exhibited signs or symptoms of COVID-19 within the last 14 days.
- ☐ I was diagnosed with COVID-19. Please indicate date of diagnosis: ________________
- ☐ I or someone in my immediate family/contact circle is currently awaiting COVID-19 test results.

The purpose of this form is to document your consent to any care you receive in this office visit, including examination, X-rays and any essential dental care. By signing below, you authorize our office to perform Dental X-Rays and or Dental Care.

I understand that even though my dental providers are taking additional environmental / infectious disease precautions in connection with my care there is no guarantee that I am not already infected with COVID-19 or may not contract it via community spread.

I understand the recommendation of dental care, any fee involved, risks and benefits of treatment, any alternatives and risks and benefits of these alternatives, and consequences of not undergoing treatment. I will advise the dental professional immediately if I experience any allergic reaction or negative side effects after dental care is rendered, if

I test positive for COVID-19 within 2 weeks of this office visit, or if I begin to exhibit any signs of acute respiratory illness such as coughing, fever and shortness of breath. I have had all my questions answered and have not been offered any guarantees. I hereby give my informed written consent for X-Rays and dental treatment for essential dental care.

☐ Verbal & Written Consent Given

Patient Name: ________________________ Date: ________________

Signature: ____

If signed by a legal representative, printed name: ________________________

Last updated: 04/08/2021

Authority/Relation: ____

This is to confirm that I have not traveled to the states listed during the Travel Ban (see below) and in the event that I choose to travel to any of the states affected by the Travel Ban, I will comply with the 14-day quarantine period upon returning to NJ. I understand that if I have traveled, I cannot be seen in the office for the 14-day quarantine period unless I am vaccinated. Currently, the States that meet the criteria for quarantine are: All US states except (NY, PA, DE, CT) and all countries outside of the US.

This list subject to change, please refer to the NJ. Gov website for updates.

Acknowledgment: ____

Date: ______________________________

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