Patient Request for Treatment
Representations and Consent

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office, and the patients, staff and other individuals who come upon the premises.

According, as a precondition to rendering treatment, I have confirmed that I have no symptoms commonly associated with COVID-19, including fever, shortness of breath, dry cough, running nose or sore throat and that I have not, within the past 14 days, traveled by airplane, been in close proximity (less than 6 feet proximity) at a gathering of 10 or more persons, or had contact with a person who has confirmed positive or suspected to be positive for COVID-19.

Please answer yes or no to the following questions.

Do you have a fever or above normal temperature? _____

Have you experienced shortness of breath or had trouble breathing? _____

Do you have a dry cough? _____

Do you have a runny nose? _____

Have you recently lost or had a reduction in your sense of smell? _____

Do you have a sore throat? _____

Have you been in contact with someone who has tested positive for COVID-19? _____

Have you tested positive for COVID-19? _____

Have you been tested for COVID-19 and are awaiting results? _____

Have you traveled outside the US in the past 14 days? _____

I consent to the performance of the treatment proposed by my dentist.

Print Name: _____ Date: _____

Signature: _____