ASSOCIATE IMPLANT & FAMILY DENTISTRY

2901 Meridian Bellingham, WA 98225
360-671-7228

COVID-19 Pandemic Treatment Consent Form

I, ____, knowingly and willingly consent to have dental treatment completed during the **COVID-19** pandemic.

I understand the **COVID-19** virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours which can transmit the **COVID-19** virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of the dental procedures, that I have an elevated risk of contracting the virus simply by being in the dental office.
- I confirm that I am **not** presenting any of the following symptoms of **COVID-19** listed below
  - Fever
  - Shortness of breath
  - Dry Cough
  - Runny nose
  - Sore throat

I understand that air travel significantly increases my risk of contracting and transmitting the **COVID-19** virus. In addition, the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry.

I verify that I have not traveled outside the United States in the past 14-days to countries that have been affected by **COVID-19**.

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14-days.

Patient/Guardian:

Signature:____**Date:**__________________