COVID-19 Pandemic Dental Treatment Consent Form for Acworth Premier Dental Care

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

I understand that COVID-19 virus has a long incubation period during which carries of the virus may now 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. Dr. Yen Tran and her team is adhering to CDC, OSHA, and ADA guidelines to prevent the spread of the virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristic of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here _____(INITIAL)

PLEASE CIRCLE THE ANSWERS THAT APPLY TO YOU

1. **Do you have a fever now or have you in the past 14 days?** *YES or NO*
2. **Have you come in contact with any confirmed COVID positive patients in the last 14 days?** *YES or NO*
3. **Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?** *YES or NO*
4. **Are you experiencing shortness of breath or difficulty breathing?** *YES or NO*
5. **Have you experienced recent loss of taste or smell?** *YES or NO*
6. **Have you traveled outside the United States in the past 14 days?** *YES or NO*
7. **Have you traveled domestically within the US by commercial airline, bus, or train within the past 14 days?** *YES or NO*
8. **Have you been tested for COVID-19 within the last 14 days?** *YES or NO*
   If yes, when where you tested? _____(Please provide exact date)
   If yes, what were the results? *POSITIVE or NEGATIVE or I haven't received my results*

I verify that all answers are answered truthfully, and I am aware that Acworth Premier Dental Care can deny treatment if I answered yes to any of the questions listed above. _____(INITIAL)

Please sign name: _____

Date: _____

ACWORTH
Premier Dental Care