COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

Downtown Dental - River North
676 N Michigan Ave #3500
Chicago, IL 60611

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

_____ *Initial* **I confirm that I do not have any of the following symptoms of COVID-19 (currently or for the last 14 days): fever, shortness of breath, dry cough, runny nose, sore throat.**

_____ *Initial* I understand while the overall risk to the general population is low, that due to the frequency of visits of other dental patients, the characteristics of the COVID-19 virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus by being in a dental office. While this dental office is taking extra precautions to safeguard me and their teammates, I accept any risk related to contraction of the virus, and I will not hold at fault this dental office, their staff, or any other affiliated entities.

_____ *Initial* Due to the nature of the COVID-19 pandemic, I understand that post-operative monitoring is difficult, and that my doctor may opt to perform these services remotely to mitigate risks to me and the dental team.

_____ *Initial* After my procedure, I understand that I may be at higher risk for further infection and agree to follow social distancing guidelines, enhanced hand hygiene, and any applicable state and local guidelines.

_____ *Initial* I confirm that I have not been in contact with a person that has been diagnosed with (or tested positive for) COVID-19 within the last 14 days.

_____ *Initial* I understand that the CDC recommends social distancing of at least 6 feet to prevent transmission of disease and this is not possible with dentistry.

_____ *Initial* I agree that if I were to exhibit any symptoms of, or am diagnosed with, COVID-19, I will immediately contact my dentist so that proper steps can be taken to limit the spread of this contagion. I also acknowledge and understand that if I have a positive COVID-19 test or I am diagnosed with COVID-19, my dentist may be required by law to disclose such fact to public health authorities.

_____ *Initial* I also understand that my dental office will be incurring substantially higher material costs for the enhanced PPE to safeguard me and the team during the COVID-19 pandemic. I have been made aware that a **$10 Enhanced COVID Safety Equipment fee** may be applied to my visit. I accept responsibility for this fee, if applicable, and agree to pay this fee at the time of service. I understand that this fee helps to offset some of the added expenses that my local office is incurring as a result of COVID and helps my dental office remain solvent.

_____ *Initial* I also understand that during the COVID-19 pandemic, my dental office may have fewer appointment slots to allow more time for preparation and enhanced disinfection between patients. I therefore agree that if I am unable to keep my scheduled appointment time, I will provide the dental office **at least 48-hour notice**. I thus acknowledge and accept a **missed appointment fee of $50** for failure to show-up at my designated appointment time or providing the office insufficient notification time (less than 48-hour notice) for any changes or cancellations to my appointment. I understand that no commercial or government dental insurance benefits cover the cost of missed appointment fees and that I am responsible for this fee.

Please sign below to acknowledge understanding and agreement with the above statements:

If patient is under 18, a parent or guardian must sign below to consent to the procedure with full understanding and acceptance of such disclosures and risks.

Patient Name: _____

Parent/Guardian Name *(if patient is under 18)*:_____

Signature _____

Date_____