COVID-19 Pandemic Dental Treatment Consent Form

I, knowingly and willingly consent to have dental treatment completed for my child, _____ 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.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

Dental procedures create aerosols which could affect spread of disease. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus. To the best of our ability, our office follows the CDC, ADA and GDA guidelines.

I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____ (Initial)

I confirm that my child is not presenting any of the following symptoms of COVID-19 listed below:

- Fever / Shortness of Breath
- Dry Cough / Runny Nose
- Sore Throat
- Altered smell/ taste or headaches

_____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And 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. _____ (Initial)

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. _____(Initial)

I give Smile Magic Dentistry, Dr. Pushpa Sundareswaran and Dr. Sharon DeSouza permission to treat my child. This may involve exam, Xray, and/or treatment that may necessitate the use of high speed drills that produce aerosols. I understand my child will be in close proximity to the doctor and other team members.

Signature: _____ Date: _____