

Dental Patient Consent Form

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our community. We ask you to acknowledge and understand the following information regarding the COVID-19 virus. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing. We are taking every precaution we can via proper sanitation techniques and personal protective equipment to prevent transmission in either direction. If you or anyone in your immediate family have experienced any covid symptoms such as runny nose, cough, sneezing, shortness of breath, nausea, or have experienced fever like symptoms, we ask you to please reschedule your appointment.

The patient, _____, will hold harmless and indemnify, the doctor, the practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors against any claims, and actions, related to COVID-19, in exchange for dental treatment during the events of COVID-19 National Emergency.

Acknowledgment

You are receiving dental care during the events of a COVID-19 National Emergency. Please be advised, judgement of any injury I may have sustained or possible transmission of COVID-19 during treatment and my decision to release has not been affected by any false statements or representations pertaining to those injuries. I understand that this action is just a business decision and agree this represents a compromise between the patient and the doctor. Accordingly, this agreement is not an admission of any liability regarding the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions. I have carefully read this release and understand its contents, and I am signing it of my own free act.

Patient/Guardian

Signature: _____ Date: _____