

COVID-19 DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care. The COVID-19 virus has a long incubation period. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office. You cannot wear a protective mask over your mouth during treatment as your health care providers need access to your mouth to render care.

A weak or compromised immune system including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy and any prior or current disease or medical condition, can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system. It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	<u>Yes</u>	<u>No</u>
Do you/they have a fever or have felt hot or feverish recently (last 14 days)?		
Do you/they have a cough, runny nose, or sore throat?		
Do you/they have shortness of breath or trouble breathing?		
Do you/they have other symptoms (gastrointestinal upset, headache, fatigue?)		
Have you/they experienced any recent loss of taste or smell?		
Have you/they tested positive for COVID-19 or awaiting results of a test?		
Have you/they been in contact with anyone with a confirmed or suspected positive test for COVID-19?		
Have you/they traveled by public transportation (e.g. air, bus, train, etc.) in the past 14 days?		

I acknowledge that I will inform Windham Dental Group, PLLC if any of my answers above changes to a "Yes" before any future appointments. *Initial* _____

I confirm that I have read the Notice above and fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system, and that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here. By signing this document, I acknowledge that I understand the information stated above, and have disclosed to my provider all conditions in my health history, and that the answers I have provided above are true and accurate.

Patient (or legal guardian) Name

Patient(or legal guardian) signature

Date