I, ________________________________, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I have been made aware of the Center for Disease Control guidelines, the recommendations of the California Dental Association, American Dental Association, and Local/State Public Health Mandates that dentists are to prioritize care that was previously postponed especially for conditions likely to lead to dental emergencies if treatment continues to be deferred. Routine dental cleanings are considered preventive in nature and may be considered based on local or regional PPE and needed supplies being available. This includes topical fluoride application, sealants, and scaling.

I understand that some dental infections, if left untreated, can lead to serious complications, including the need for hospitalization.

I confirm I am seeking treatment for a condition that meets these criteria.

Procedure Issues

I understand that the treatment provided by my dentist is intended to ONLY eliminate or reduce the infection and/or pain that I am currently experiencing and may not be definitive care. There may be a need for additional procedures to return the state of my mouth to optimum health. Failure to seek additional treatment that my doctor recommends may result in further issues, including pain, infection, and loss of teeth/bone and/or function.

Due to the extreme nature of this pandemic, I understand that post-operative monitoring is difficult, in-office visits are not recommended, and that my doctor may opt to perform these services remotely.

I understand that it is imperative that I take the medications as prescribed. I further understand that certain medications, such as opioid “pain” medications, cannot be called into pharmacies.
Unique Circumstances

__________ Some dental procedures create water spray (aerosol), which is how the disease is spread. The ultrafine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

__________ 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.

__________ 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 by being in a dental office.

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

__________ I confirm that I have not been in contact with a person that has been diagnosed with COVID19 within the last 14 days.

__________ 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.

__________ 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 hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be completely successful in resolving my pain and/or infection. It is anticipated that the treatment will provide benefit in reducing the cause of this condition. However, due to individual patient differences and the extenuating circumstances, there exists a risk of failure relapse, selective retreatment, or worsening of my present condition, including the loss of additional teeth/bone, despite the best care. I have read, comprehend, and agree with the above statements.

Name______________________________________ Date_______________________