



Norbo Dental
COVID-19 Pandemic Dental Treatment Consent Form

I, _____ (patient name and guardian name if applicable),
knowingly and willingly consent to have dental treatment completed 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.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- 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 I am **NOT** presenting any of the following symptoms of COVID-19 listed below:

- Fever _____ (Initial)
- Shortness of Breath _____ (Initial)
- Dry Cough _____ (Initial)
- Runny Nose _____ (Initial)
- Sore Throat _____ (Initial)
- Recent loss of taste or smell _____ (Initial)
- Other flu-like symptoms including such as gastrointestinal upset, headache, fatigue _____ (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. I understand this is not possible with dentistry. _____ (Initial)

- I verify that I have not traveled outside the United States in the past 14 days. _____ (Initial)
- 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 verify that I have not been in contact with any person who has tested positive for COVID-19. _____ (Initial)
- I consent to having my body temperature taken by means of a temporal thermometer as a tool for screening prior to my dental appointment today. _____ (Initial)

PATIENT or Guardian _____ Date _____

Guardian Name _____ Date _____

TO BE COMPLETED BY THE OFFICE STAFF:

Patient Temperature: _____ Staff Witness: _____