

Dental Treatment Consent and Affirmation Form
COVID-19 Reopening

1. I knowingly and willingly consent to dental treatment at Metropolitan Dental Care, by Dr. _____ (Dr. 's name to be filled out by Metro Dental Care) and any designated associates and employees during the reopening phase of COVID-19.
2. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has COVID-19 and who does not given the current limitations and availability in COVID-19 viral testing.
3. Risk of transmission: I understand that due to the frequency of visits of other care dental patients, 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, even though standard precautions are being observed.
4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
 - A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher
 - B. Shortness of breath
 - C. Dry cough
 - D. Runny nose
 - E. Sore throat.
 - F. Diminished sense of taste or smell
5. Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in paragraph 4 (#4) in the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

Patient's name (please print) _____ Date _____

Signature of patient, legal guardian or authorized representative _____

Date _____

Witness to signature _____ Date _____