EDWARDS
FAMILY DENTISTRY

General Consent to Dental Treatment During COVID-19

Patient's Name: _____ Birthdate: _____

Thank you for choosing Edwards Family Dentistry for your dental needs. Our goal is to provide you with high quality dental care. The Arkansas Department of Health (ADoH) has recommended that dental facilities and healthcare providers may resume services that require minimal protective equipment on May 11, 2020. Because dental work often creates aerosols, it carries an added risk of spreading COVID-19. This form is being provided to you to identify potential risks of dental treatment during COVID-19. If you or a member of your household are experiencing symptoms of COVID-19 (e.g., fever, cough, shortness of breath), **please alert a member of our staff immediately**. We must be aware of such symptoms or any positive COVID-19 tests immediately to protect our dental office.

While all dental care has certain inherent risks and complications, patients face additional risks during the COVID-19 pandemic. These include, but are not limited to, increased risk of exposure to COVID-19. While we are taking all reasonable precautions to prevent the spread of COVID-19, it is impossible to eliminate that risk. Dentists and/or staff are exposed to multiple patients, who could be asymptomatic carriers of COVID-19. Complications of COVID-19 may include acute respiratory distress syndrome, irregular heart rate, cardiovascular shock, severe muscle pain, fatigue, heart damage or heart attack. The risk of complications is increased for individuals aged 65 and older, and individuals with compromised immune systems and/or chronic disease.

By signing this form, you acknowledge that in-person treatment for your dental condition presents increased risk of contracting COVID-19. You further acknowledge that for us to perform the treatment, we must be closer than the CDC recommended 6 ft. in proximity. You further agree that you will follow certain procedures as required by the ADOH, including but not limited to hand washing and wearing a surgical mask at certain times.

IF YOU EXPERIENCE ANY COVID-19 SYMPTOMS OR TEST POSITIVE FOR COVID-19 AFTER RECEIVING DENTAL TREATMENT, PLEASE CONTACT YOUR PRIMARY HEALTH CARE PROVIDER AND OUR DENTAL OFFICE IMMEDIATELY.

I give consent for myself/my child to receive dental treatment during the COVID-19 pandemic deemed necessary or recommended by the providers at this office.

This consent shall be considered in effect until rescinded or revoked.

_____ _____

(Print your name) (Relationship if minor)

_____ _____

(Signature) (Date)