North Star Dentistry

Care You Deserve, Experience You Love, Smile You Desire!

COVID-19 Pandemic Dental Treatment Informed Consent and Questionnaire Form

I, _____, 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. The ultra-fine nature of the spray/ aerosols 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 may have an elevated risk of contracting the virus simply by being in a dental office. _____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. I also understand that the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has traveled recently, and this is not possible with dentistry. _____ (Initial)

When was the last time you/ they took pain/ fever medicine ex Tylenol, ibuprofen, tramadol, aspirin, hydrocodone etc?

_____

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 and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you/they (if you are the guardian) have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes No
Do you/they have a fever or above normal temperature (14-21 days)?	☐ ☐
Have you/ they experienced shortness of breath or had trouble breathing?	☐ ☐
Do you/ they have a dry cough?	☐ ☐
Do you/ they have a runny nose?	☐ ☐
Have you/they recently lost or had a reduction in your sense of smell or taste?	☐ ☐
Do you/ they have a sore throat?	☐ ☐
Do you/they have heart or lung or kidney disease, diabetes or any auto-immune disorders?	☐ ☐
Do you/ they have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ ☐
Have you/ they tested positive for COVID-19?	☐ ☐
Have you/ they been tested for COVID-19 and are awaiting results?	☐ ☐
Have you/ they traveled outside the United States by air or cruise ship in the past 14 days?	☐ ☐
Have you/ they traveled within the United States by air, bus or train with in the past 14 days?	☐ ☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.
By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____
Signature Date

_____
Witness