Dental Treatment Consent Form required for all dental services in Minnesota

(for use starting May 18, 2020)

I,
Name: _____ knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic, which is likely to be present in our community for the next year or longer.

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 for sure who has it and who does not given the current limits in virus testing.

Dental procedures create water spray and droplets. The disease is spread by water droplets in the air. The virus has the potential to linger in the air for uncertain amount of time, during which it can transmit the COVID-19 virus.

- I understand that due to the characteristics of the virus, that I have an elevated risk of contracting the virus simply by being anywhere that an infected person has been recently. This includes the dental office.

Please Initial required

- I have been made aware of the CDC, MSDA, and ADA guidelines that under the current pandemic, elective procedures, such as routine hygiene visits, may resume May 11, 2020. Initially, higher risk dental visits will focus on treatment of pain, infection, breakage, or conditions that have the potential to inhibit normal operation of teeth, the mouth, or the rest of the body within the next 3-6 months. This means that some portions of your treatment may still be delayed or altered to reduce ambient risk to all patients.

Please Initial required

- I understand that all reasonable precautions and best practices have been implemented to reduce your risk of exposure to COVID-19. I understand that no one can promise an elimination of risk. I understand I can get a verbal or written or visual explanation of the changes made to reduce the transmission risk in this office.

Please Initial required

I confirm that I am not presenting with any of the following symptoms of COVOID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough

- Runny Nose
- Sore Throat
- Loss of Smell or Taste
- Or any other commonly identified COVID-19 symptom

Please Initial required

- The CDC recommends social distancing of at least 6 feet and to wear a mask when in public, and that this is not possible for most of your visit in a dental office.

Please Initial required

- I verify that I have not traveled outside the United States or domestically by airline, bus or train in the past 14 days. I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. A 14-day isolation period is required after any potential exposure.

Please Initial required

- If initialed, I verify that I, or someone in my household with whom I have contact, has participated in at least one of the following activities in the last 14 days: been inside a grocery store or other establishment, accepted items from a delivery service, utilized a drive-thru (bank/food/etc.), been within 6 feet of another person outside your home, or been inside a medical facility or pharmacy. I understand that ANY contact, even minimal, will put me at risk to contract coronavirus.

Please Initial required

Verification

By signing this COVID-19 Pandemic Emergency Dental Treatment Consent Form, I agree that my I understand that even though every precaution has been taken, there exists the potential for exposure.

☐ Yes

Full name Patient/Legal Guardian (First Name/Last Name) required

_____

Today's Date

Signature required _____