Capezio Loiben Pediatric Dentistry

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE
AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. We have taken extensive safety precautions in addition to our standard precautions to limit the risk of virus transmission to both our staff and patients. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

I knowingly and willingly consent to dental treatment at Capezio Loiben Pediatric Dentistry. by Dr. Loiben and any designated associates and employees during the reopening phase of COVID-19.

I understand that the COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office, even through the standard precautions are being observed.

I am unaware of myself or my child being a possible carrier or infected. I confirm that neither myself nor my child have tested positive for COVID-19 in last 30 days and that my child does not have any of the following symptoms: fever, shortness of breath, dry cough, runny nose, sore throat, diminished sense of taste or smell.

Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of 15 minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone who has had any of the above stated symptoms of COVID-19.

I confirm that I have read the notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that my child can contract the COVID-19 virus from outside the office and unrelated to my visit here. I voluntarily assume any and all medical/dental risks, including substantial and significant risk of serious harm, if any, which may be associated with my child's 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. I have read and understand the information stated above:

_____	_____
Child's Name (Please Print)	Parent's Name (Please Print)
_____	_____
Signature of Caregiver/Responsible Party	Witness

Patient Name: _____ Capezio Loiben Pediatric Dentistry

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 OUTBREAK

Dear Patient/Parent (for patients under 18 years old):

You have come to our office today for a routine dental evaluation and/or treatment during the COVID-19 outbreak. Please be advised of the following:

While our office complies with The Centers for Disease Control and Prevention guidelines and the American Dental Association infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are in a place of public accommodation, other persons (including other patients and parents) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of screening questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

_____ _____

PATIENT/RESPONSIBLE PARTY DATE

PLEASE ANSWER "YES" OR "NO" **WITH YOUR INITIALS**, TO THE FOLLOWING QUESTIONS:

(your initials)

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? _____ YES _____ NO

DO YOU NOW OR HAVE YOU RECENTLY HAD A FEVER? _____YES _____ NO

DO YOU HAVE SHORTNESS OF BREATH? _____YES _____ NO

DO YOU HAVE A SORE THROAT OR DRY COUGH? _____YES _____ NO

DO YO HAVE A RUNNY NOSE? _____YES _____ NO

DO YOU HAVE SNEEZING, WATERY EYES AND/OR SINUS PAIN/PRESSURE?
THAT IS UNUSUAL, AND NOT RELATED TO SEASONAL ALLERGIES? _____YES _____ NO

HAVE YOU BEEN EXPERIENCING HEADACHES, FATIGUE OR WEAKNESS? _____YES _____ NO

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? _____YES _____ NO

ARE YOU/YOUR FAMILY MEMBERS IN CONTACT WITH ANY CONFIRMED COVID-J19 POSITIVE PATIENTS? _____YES _____ NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY? _____YES _____ NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES? _____YES _____ NO

IF SO, WHERE? _____