# COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I, _____ (Or guardian if under 19 years of age), knowingly and willingly consent to having dental treatment by NEW JERSEY ENDODONTICS or DR. THOMAS ALLEN during the COVID-19 pandemic.

☐ Due to the current national limitations in COVID-19 testing and the incubation period of the virus, it is impossible to identify carriers of COVID-19. Thus, I confirm that I am not currently presenting any of the following symptoms of COVID-19, nor have a presented the following symptoms for the last fourteen (14) days:

- Fever (temperature of **100.4°** F (38° C) or higher)
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat.

☐ I verify that I have not been diagnosed with COVID-19 within the last fourteen (14) days, and I have not been in contact with any person(s) diagnosed with COVID-19 within the last fourteen (14) days to the best of my knowledge.

☐ I acknowledge the increased risk of contracting and transmitting the virus during any form of travel, and I deny engaging in domestic or international travel by commercial airline, bus, or train, within the last fourteen (14) days.

☐ I verify that I have followed the CDC's recommendations to practice social distancing of at least six (6) feet and to self-quarantine for a period of fourteen (14) days if infected by the virus.

☐ I am aware that there is a risk of contracting the virus in this or any dental office, given the fact that patients must enter and exit the practice for routine dental care, the characteristics of the virus, and the aerosolized nature of dental procedures, therefore I waive my right to hold NEW JERSEY ENDODONTICS liable should I contract COVID-19 following my dental procedure(s).

**BY SIGNING MY NAME BELOW, I ATTEST THAT I HAVE ANSWERED THE ABOVE QUESTIONS TRUTHFULLY TO TH BEST OF MY KNOWLEDGE.**

_____ _____

Signature of Patient or guardian if under age of 18 Date