I, _____ **(PRINT NAME)**, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

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.

It is also important that you disclose to this office any indication of having been exposed to COVID-19 or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	YES	**NO**
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or had a reduction in your sense of smell or taste?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for Covid-19?		
Have you tested positive for Covid-19?		
Have you been tested for Covid-19 and are awaiting results?		
Have you traveled outside the United States by air or cruise ship in the past 14 days?		
Have you traveled within the United States by air, bus, or train within the past 14 days?		

I fully understand and acknowledge the above information regarding a compromised immune system. I will disclose to my provider any conditions in my health history which may result in a compromised immune system.

I fully understand that in the dental setting, despite all the new precautions, rules, and regulations we are following, there is always risk when entering a public setting to contract this novel COVID-19 virus. _____ **(INITIAL)**

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Patient Signature: _____ Date: _____

Witness Signature: _____