JOHN R. BUSH, D.M.D.. P.C.

**COVID-19 Pandemic Dental Treatment Consent Form**

**I, _____, knowingly and willingly consent to have emergency 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 of testing.**

**Dental procedures create water spray which is how the disease is spread. The ultrafine nature of the spray 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 have an elevated risk of contracting the virus simply by being in the dental office._____(Initial)**

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

*** Fever**

*** S*hortness of Breath***

*** Dry Cough**

*** Runny Nose**

*** Sore Throat _____(Initial)**

**I understand that air travel significantly increases my risk of contracting and transmitting the COVID19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry._____(Initial)**

*** I verify that I have not traveled outside the United States in the last 21 days to countries that have been affected by COVID_19._____(Initial)**

***I will notify the office if I develop any of the above symptoms of Covid-19 up to 14 days after. _____ (Initial)**

NAME:_____ DATE_____