

Drs. Harrison and Tucker

Family Dentistry

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COVID-19 Pandemic Dental treatment Consent Form

I, _____ (name), knowingly and willingly consent to have 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 may be highly contagious. It is impossible to determine who has the virus and who does not with the limits of the COVID-19 virus testing.

Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus.

_____ **(initial)** I confirm that I have **NOT** been in contact with a confirmed Covid-19 positive patient.
If yes notify office staff immediately.

_____ **(initial)** I confirm that I have not had a fever in the last 14 days.

_____ **(initial)** I confirm that I am **NOT presenting** any of the following symptoms of COVID-19 listed below:

- Fatigue
- Loss of sense of taste and smell
- Runny nose
- Gastrointestinal upset
- Shortness of breath
- Dry cough
- Sore throat
- Headache

(YES or NO) Do you have heart disease, lung disease, diabetes, or any auto immune disorder?

_____ **(initial)** If yes, I acknowledge that these conditions place me in the high-risk category for COVID-19.

_____ **(initial)** I understand that travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period 14 days to anyone who has traveled. Social distancing in dentistry is not possible.

NAME _____ Date of Birth _____ Date _____

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