COVID-19 Pandemic Dental Treatment Consent Form

I confirm that I have not knowingly been in contact with someone who has tested positive for COVID-19 or someone who has been under protective quarantine for COVID-19 in the past 14 days.

I confirm that I am not awaiting results from a recent COVID-19 test.

I confirm that I have not traveled to any of the restricted states in the last 14 days.

I confirm that I have not presented with any of the following symptoms below in the past 14 days.

- Shortness of breath/difficulty breathing
- Dry cough
- Runny nose
- Sore throat
- Loss of taste or smell
- Fever / Chills
- Muscle Pain

Print Name: _____

Signature: _____Date: _____