COVID-19 PANDEMIC CONSENT

1. I knowingly and willingly consent to dental treatment by Dr. M. Sean Lorscheider and any designated associates and employees during the COVID-19 pandemic.

2. I understand that Dr. M. Sean Lorscheider is following the CDC guidelines for treatment protocol and infection control.

3. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the past 30 days and that I am not presenting with any of the following symptoms of COVID-19:
   - A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher.
   - B. Shortness of breath
   - C. Dry cough
   - D. Runny nose
   - E. Sore throat
   - F. Diminished sense of taste and/or smell

4. Contact with infected: I confirm that I have not been in close contact defined as 6 feet or less for a duration of fifteen minutes or more with someone who has tested positive for COVID-19 in the last 14 days.

5. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

6. I understand the COVID-19 virus has a long incubation period, during which carriers of the virus may not show symptoms, yet are still highly contagious. It is impossible to determine who has it and who does not, given the current limitations and availability in COVID-19 viral testing.

7. Risk of transmission: I understand that due to the frequency of visits of other dental patients, characteristics of the virus, and the characteristics of dental procedures, that I may have an elevated risk of contracting the virus simply by being in a dental office, even though the CDC and Utah Department of Health guidelines are being observed.

8. INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 to the best of my knowledge. I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended have been explained to me if necessary and I have been given the opportunity to ask questions.

9. The American Academy of Pediatric Dentistry (AAPD) and the American Dental Association (ADA) have recently released guidance for dental practices regarding the use of COVID-19 related Personal Protective Equipment (PPE) as outlined by the Centers for Disease Control (CDC). with these new CDC recommendations comes a rise in expenses for your dental practice. A $10.00 PPE fee will be charged per visit, per patient. Most insurance companies are covering the cost of the added PPE fee, however, if your insurance company does not, it will be the responsibility of the patient.

Patient Name (print): ______________________________ Date: ____________________

Patient Signature: ______________________________
(Patient, Legal Guardian, or Authorized Agent of Patient)

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