

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

1. I knowingly and willingly consent to dental treatment by Dr. ANDRUS and any designated associates and employees during the COVID-19 pandemic.
2. I understand that Dr. ANDRUS is following CDC guidelines as far as treatment protocols 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 last 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 38.1 degrees Celsius or higher
  - B. Shortness of breath
  - C. Dry cough
  - D. Runny nose
  - E. Sore throat.
  - F. Diminished sense of taste and smell
4. Contact with infected: I confirm that I have not knowingly 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, or with anyone that has had the above stated symptoms 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 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 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with 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.

\_\_\_\_\_  
Patient's name (please print)

\_\_\_\_\_  
Signature of patient, legal guardian or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to signature

\_\_\_\_\_  
Date