This is a suggested sample for use in developing an informed consent form and is for reference purposes only. This document does not establish a standard of care. It is intended for use as a tool to reduce malpractice risk and should be edited to fit your practice and to meet the legal requirements of your individual state(s). It is also intended to improve communication with patients so they may better understand the treatment recommended. **NCMIC/PSIC does not tell the practitioner what to document, but instead advises the practitioner to use their clinical judgment in determining the need for informed consent and the content of such a form.**

COVID-19 Pandemic Emergency Dental Treatment Consent Form

Patient Name: _____ Date: _____

Treatment & Tooth #: _____

Dental Care Team Members Involved in Care: _____

I understand dentistry is not an exact science and there is no guarantee of results. When undergoing emergency dental treatment during the COVID-19 Pandemic there are certain risks and increased potential for infection, in addition to a potential for unsuccessful results from the procedure. I knowingly and willingly consent to receive emergency dental treatment during the COVID-19 pandemic. _____ (Initial).

This dental provider has engaged in all appropriate CDC, state and local health agency recommendations regarding sanitation [as available], personal protective equipment [as available], and safety protocols to slow the spread of COVID-19. _____ (Intitial)

In order to minimize these risks, my dental provider is requesting additional information and informed consent from the patient. _____ (Initial)

In order to help keep other patients and dental staff safe and healthy, I am confirming that I do not present with any of the following symptoms of COVID-19: fever, shortness of breath, dry cough, or sore throat. _____ (Initial).

I confirm that I have not travelled internationally in the last 14 days to a country affected by COVID-19 or travelled domestically within the last 14 days by plane, train, or bus. _____ (Initial).

I confirm that I have not been diagnosed with COVID-19 or been in close contact [less than 6ft.] with another person who has been diagnosed or is awaiting results of testing for COVID-19. _____ (Initial).

I understand that COVID-19 has a long incubation period during which the 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 current limitations in virus testing. _____ (Initial)

Dental procedures present the possibility of spreading potentially infected bodily fluids through water spray. This spray can linger in the air for unknown periods of time, which can cause the unwitting transmission of the COVID-19, regardless of the highest sanitation procedures being followed. _____ (Initial)

I understand that by receiving emergency dental treatment, due to the frequency of visits of other dental patients, the characteristics of the virus, and the nature of dental treatment that I have an elevated risk of contracting the virus simply by being in a dental office. _____ (Initial).

Under the current COVID-19, CDC, ADA, and local dental association guidelines all non-urgent dental care is not recommended. This dental visit is limited to the treatment of severe pain that inhibits activities of daily living, serious infection, life threatening conditions, threat of permanent dysfunction, or metastasis that could occur within the next 3 months. I confirm that I am seeking treatment for a condition that meets these criteria. _____ (Initial).

***To be signed in addition to standard consent form for treatment performed.

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If I cannot truthfully sign any of the above statements, the dentist has strongly encourage me to contact my primary physician or public health department to determine if I should be seen or tested before coming in for any dental care. _____ (Initial)

This dental provider reserves the right to contact their local and state health department authorities to report any Patient suspected of having COVID-19. _____ (Initial)

_____ _____

Patient: Date:

_____ _____

Witness: Date:

***To be signed in addition to standard consent form for treatment performed.