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EMERGENCY CONSENT FORM FOR DENTAL TREATMENT

CORONAVIRUS (COVID-19)

I the undersigned, _____ (patient's name or parent if patient is a minor / legal representative), on behalf of myself or on behalf of _____ (child or ward patient) hereby request dental treatment from the office of SMART ORTHODONTICS and its providers. I understand that my request for dental treatment is during a time of the world-wide Coronavirus (COVID-19) pandemic and I understand that this office is not able to provide this dental treatment without my acknowledgement of the matters set forth below and my agreement to notify this office in the future of matters set out below. I knowingly and willingly consent to the dental treatment. **THIS OFFICE HAS TAKEN ALL THE POSSIBLE PROVISIONS AND PRECAUTIONS TO PROTECT THE DOCTORS, STAFF AND PATIENTS FROM COVID-19, HOWEVER THERE IS STILL A RISK THAT IS BEYOND OUR CONTROL.**

As indicated by my initials, ***I acknowledge and understand each of the following:***

_____ (Initial) I understand that due to the frequency of visits of other dental patients, the characteristics of dental procedures and the characteristics of COVID-19, I have an elevated risk of contracting COVID-19 by being in a dental office.

_____ (Initial) I understand that the Center for Disease Control ("CDC") recommends social distancing of at least six (6) feet for a period of fourteen (14) days to anyone that has been exposed to COVID-19 and this is not possible when performing this emergency dental treatment.

_____ (Initial) I understand the CDC and American Dental Association ("ADA") guidelines that non-urgent dental care is not recommended due to the COVID-19 pandemic and that all dental visits should be limited to treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth and issues that may cause any of these in the next 3-6 months.

_____ (Initial) I understand dental procedures create water spray which may be a source for transmission of COVID-19 and that the ultra-fine nature of the spray can linger in the air from several minutes to several hours, which may be a source for transmission of COVID-19.

_____ (Initial) I understand there is a long incubation period for COVID-19 and during this time carriers of COVID-19 may not show symptoms and may not be aware they have contracted COVID-19 but they may still be highly contagious. I understand that due to limited available resources it is not currently possible to determine who may have COVID-19 and not yet be exhibiting symptoms.

As indicated by my initials, in order to receive emergency dental treatment, ***I verify and confirm to the Practice each of the following:***

_____ (Initial) I am not currently having and I have not had in the past fourteen (14) days any of the following COVID-19 symptoms:

- Sweating / Fever
- Fatigue
- Sore Throat
- Dry cough
- Shortness of Breath / Difficulty breathing especially after coughing

_____ (Initial) I have not traveled outside the United States in the past fourteen (14) days to countries that have been affected by COVID-19.

_____ (Initial) I am seeking treatment for condition that meets the criteria established by the CDC and ADA as indicated above.

_____ (Initial) I have not traveled domestically in the United States by commercial airline, bus, train or other means of public transportation in the past fourteen (14) days.

As indicated by my initials, in order to receive the emergency dental treatment and in order assist in curbing down the spread of COVID-19, ***I agree as follows:***

_____ (Initial) If during the next fourteen (14) days I exhibit any symptoms of COVID-19, I will inform this dental office immediately and I will also inform this office of any testing results or quarantine orders I receive.

_____ (Initial) I understand that my communication with this office regarding any COVID-19 symptoms is critical to curb down the spread of COVID-19 and to allow the office to provide informed consent to other patients and to otherwise take protection measures.

_____ (Initial) I understand this office will not share or disseminate any of my Protected Health Information for any unlawful or prohibited purpose.

Patient Name: _____ Parent or Legal Guardian: _____

Date: _____