Andrew R. Fletcher, DDS

A Professional Dental Corporation

COVID-19 Pandemic Emergency Dental Treatment Consent Form

I, _____, knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic. I have been made aware of the Center for Disease Control guidelines, the recommendations of the California Dental Association, American Dental Association, and Local/State Public Health Mandates that all non-urgent dental care is not recommended. At this time, dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. I understand that some dental infections, if left untreated, can lead to serious complications, including the need for hospitalization.

_____ I confirm I am seeking treatment for a condition that meets these criteria.

Procedure Issues

_____ I understand that the treatment provided by my dentist is intended to ONLY eliminate or reduce the infection and/or pain that I am currently experiencing and may not be definitive care. There may be a need for additional procedures to return the state of my mouth to optimum health. Failure to seek additional treatment that my doctor recommends may result in further issues, including pain, infection, and loss of teeth/bone and/or function.

_____ Due to the extreme nature of this pandemic, I understand that post-operative monitoring is difficult, in-office visits are not recommended, and that my doctor may opt to perform these services remotely.

_____ After my procedure, I understand that I may be at higher risk for further infection and agree to remain at home, in compliance with the state “Shelter In Place” mandates.

_____ I understand that to mitigate these risks, it is imperative that I take the medications as prescribed. I further understand that certain medications, such as opioid “pain” medications, cannot be called into pharmacies.

Unique Circumstances

_____ Dental procedures create water spray (aerosol), which is how the disease is spread. The ultra- fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

_____ I understand the COVID-19 virus has a long incubation period during which 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 the current limits in virus testing.

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

_____ I have had no major changes in my health in the past 1 month.

_____ I confirm that I do not have any of the following symptoms of COVOID-19: fever, shortness of breath, dry cough, runny nose, sore throat currently, or for the last 14 days.

_____ I confirm that I have not been in contact with a person that has been diagnosed with COVID- 19 within the last 14 days.

_____ I confirm that I have not been out of the country within the last 14 days.

_____ I understand that the CDC recommends social distancing of at least 6 feet to prevent transmission of disease and this is not possible with dentistry.

_____ I agree that, if I were to exhibit any symptoms of, or am diagnosed with, COVID-19, I will immediately contact my dentist so that proper steps can be taken to limit the spread of this contagion.

_____ I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be completely successful in resolving my pain and/or infection. It is anticipated that the treatment will provide benefit in reducing the cause of this condition. However, due to individual patient differences and the extenuating circumstances, there exists a risk of failure relapse, selective retreatment, or worsening of my present condition, including the loss of additional teeth/bone, despite the best care.

I have read, comprehend, and agree with the above statements.

Signature _____

Date _____

Oral Temperature _____