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General & Family Dentistry
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Please Fill Out, Download, Sign and e-mail to: office@drjohncarollo.com
This is a one time form prior to your first visit with our office post COVID-19!

COVID-19 Pandemic Dental & Dental Sleep Medicine Treatment Consent Form

I, _____, knowingly and willingly consent to have my dental treatment and/or dental sleep medicine, (DSM), treatment done during the COVID-19 pandemic.

I understand the COVID-19 virus has an incubation period during which carriers of the virus may not show symptoms and still be contagious. It is not possible to determine who has this virus and who does not have this virus given the current limits of virus testing; or if someone has actually had the COVID-19 virus test.

Dental procedures create aerosols which can spread this virus. The ultra-fine nature of these aerosols can linger in the air for a period of time, which can sometimes transmit the COVID-19 virus.

- 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 a risk of contracting the virus simply by being in a dental office. _____ (Initial)
- I have been made aware of the CDC, (Center of Disease Control and Prevention), New Jersey Division of Consumer Affairs, and ADA (American Dental Association) guidelines that under the current pandemic dental care is allowed. Dental visits that may cause anything listed above within the COVID-19 time frame. _____ (Initial)
- I confirm I am seeking treatment for my dental and/or DSM needs or that of my minor child. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- ☐ Fever
- ☐ Shortness of Breath
- ☐ Loss of Taste and Smell
- ☐ Dry Cough
- ☐ Runny Nose
- ☐ Sore Throat
- ☐ _____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____ (Initial)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _____ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____(Initial)

Patient's Name_____ Date_____

Patient's Signature: _____

Parent's Signature if patient is a minor: _____