Boyle Heights Dental Care
2206 E. Cesar E. Chavez Ave
Los Angeles, CA 90033
323-265-3680

COVID-19 Pandemic Dental Treatment Consent Form

Patient Name: _____
Date: _____

I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

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.

Dental Procedures create water spray 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 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 simply by being in a dental office.
- I have been made aware of the CDC and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. 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 confirm I am seeking treatment for a condition that meets these criteria.

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

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- _____ (Initial)

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

- 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.
- I verify that I have not traveled domestically within the United States by commercial airline or any means of transportation within the past 14 days.

Patient (or Legal Guardian) Signature: _____ Date: _____