COVID-19 Patient Consent Form

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

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office and the patients, staff and other individuals who come upon the premises.

Do you have or have you had any of the following symptoms of COVID-19 in the last 14 days?

Fever or above normal temperature?	YES	NO
Shortness of breath or difficulty breathing?	YES	NO
Cough?	YES	NO
Runny nose or congestion?	YES	NO

Have you been in contact with someone who tested positive for COVID-19?	YES	NO
Have you travelled outside of New Jersey in the last 14 days?	YES	NO

if so, where? ____

I certify that the above facts are true to the best of my knowledge and I consent to the performance of the treatment proposed by my dentist

Signature: ____

Date: __________________________

Patient Temperature (Office Use Only): _______________________