COVID-19 Consent Form

Patient Advisory and Acknowledgement:
Receiving Dental Treatment During the COVID-19 Pandemic

Please complete this form the day before or day of your child's appointment

Dear Patient:

You have come to Wagner Pediatric Dentistry, LLC for a routine evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

-While our office complies with the State Health Department and Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

-Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge. You are also acknowledging the option of rescheduling your child's appointment.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers. Please complete this form 24-hrs before your child's appointment.

Please answer "Yes" or "No" with your initials to the following questions:

Is your child currently awaiting the results of a COVID-19 test?	___ YES	___ NO
Does your child have a fever?	___ YES	___ NO
Does your child have shortness of breath?	___ YES	___ NO
Does your child have a dry cough?	___ YES	___ NO
Does your child have a runny nose?	___ YES	___ NO
Does your child have a sore throat?	___ YES	___ NO
Does your child have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?	___ YES	___ NO
Has your child experienced headaches, fatigue, or weakness?	___ YES	___ NO
Has your child lost his/her sense of taste and/or smell?	___ YES	___ NO
Within the last 14 days have you or your child travelled to any foreign country?	___ YES	___ NO
Within the last 14 days, have you or your child travelled within the United States?	___ YES	___ NO

If so, where? _____

Child's Name _____ Date of Appointment_____

Relationship to Patient _____

Signature _____

By signing this document you are consenting to treatment under the conditions described above. You are also completing this form <24 hours before my child's scheduled appointment