**COVID-19 Dental Visit Consent Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, knowingly and willingly consent to Dublin Metro Dental for my dental visit/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 also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.
* I have been made aware of the CDC, ODA and ADA guidelines that under the current pandemic, dental visits are allowed but special precautions are to be followed.

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

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.

* I verify that I have not travelled outside the United States in the past 14 days.
* I verify that I have not travelled domestically within the United States by commercial airline, bus or train within the past 14 days.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_