## **COVID-19 Dental Treatment Consent Form**

I,	, knowingly and willingly give consent for
myself or my dependent	
treatment completed during the COVID-19 pande	mic.
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Furthermore, I confirm that I am not presenting an below:	y of the following symptoms of COVID-19 listed
<ul> <li>Shortness of breath</li> </ul>	
Dry Cough	
<ul> <li>Sneezing / Runny nose</li> </ul>	
• Sore Throat	
• Fatigue	
<ul> <li>Sweating</li> </ul>	initial
practice immediately and will inform them of any medical physician. I understand this continues con curb the spread of the virus and to allow the practic	bit symptoms of the COVID-19 virus, I will inform the testing results or quarantine orders I receive from a mmunication with the practice is essential to help to be to provide informed consent to other patients and to the practice will not share of disseminate any of my rohibited purpose.
	initial
Patient Name:	
Signature:	
Date:	