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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 its patients, staff and other individuals who come upon the premises.

Accordingly, as a precondition to rendering treatment, I have confirmed that I have no symptoms commonly associated with Covid-19, including fever, shortness of breath, dry cough, running nose or sore throat and that I have not, within the past 14 days, traveled by airplane, been in close proximity (less than 6 feet proximity) at a gathering of 10 or more persons, or had close contact with a person who has confirmed positive or suspected to be positive for COVID-19.

Thank you for understanding.

I consent to the performance of the treatment proposed by my dentist.

Name: _____

Signature: _____

Date: _____

Temperature: _____