**William L. Farrell, DDS, FAGD**
*Fellow – Academy of General Dentistry*
*Fellow – American Academy of Forensic Sciences*
*Diplomate – American Board of Forensic Odontology*

*This patient disclosure forms seeks information from you that we must consider before making treatment decisions on the circumstance of the COVID-19 virus.
*A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling your appointment after discussing any such conditions with us.
*It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

| | Yes | No |
|---|---|---|
| **Do you have a fever, or have you felt hot or feverish recently (In last 21 days)?.....** | | |
| **Have you experienced shortness of breath or had trouble breathing?.....** | | |
| **Do you have a dry cough?.....** | | |
| **Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?.....** | | |
| **Have you experienced recent loss of taste or smell?.....** | | |
| **Have you been in contact with someone who tested positive for COVID-19?.....** | | |
| **Are you over the age of 60?.....** | | |
| **Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders? .....** | | |
| **Have you traveled in the past 14 days to any regions affected by COVID-19?.....** | | |

I fully understand and acknowledge the above information stated above, the risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

**Patient's Name** **Signature of patient (Parent or Guardian if Minor)** **Date**

********** PLEASE FLIP OVER, READ, AND SIGN THE BACK PAGE **********

## COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long period of time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are "potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection." The ADA also recommends that urgent dental care which "focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk infection and to alleviate the burden on hospital emergency departments" be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

**I have read and fully understand and acknowledge the above information stated above, the risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.**

_____ _____ _____

**Signature of patient (Parent or Guardian if Minor)** **William L. Farrell, DDS** **Date**

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