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Consent for Treatment During COVID-19 Pandemic

As you are aware, healthcare offices are experiencing unprecedented changes and demand associated with the COVID-19 pandemic. Brewster Family Dental has implemented a variety of safety measures in an effort to protect its patients and employees. These measures include, but are not limited to, strict adherence to rules and guidelines implemented by the Centers for Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA), in addition to various best practices related to personal protective equipment and exposure control.

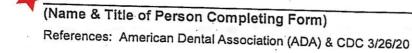
However, despite these best efforts, nothing can eliminate the risk of exposure to COVID-19 entirely. By signing this consent, you understand this risk exists and shall hold the dental practice where you receive treatment harmless from any COVID-19 related allegations. You further agree, taking into consideration this risk, to proceed with your prescribed dental procedure (s).

Patient Name:	
Patient Signature:	
Date:	

	(*)		
COVID 10 Delicate Committee			
COVID-19 Patient Screening Tool			
<u> </u>			
(Patient Name)	(Accou	(Account Number)	
Have you traveled to internationally in the last 14 days?		YES	NO
If Yes, where?			-110
2) Have you been discressed with			
2) Have you been diagnosed with or suspected of having COVID-19?			
 Do you live with someone who has been diagnosed with or under investigation. 	stigation for COVID-		
19?			1
Have you been in close contact with another person who has been dia investigation for COVID-192			
investigation for COVID-19?	gnosed with or under	,	
i) Do you have a court for the			E 83 1
5) Do you have a cough, fever* or shortness of breath (difficulty breathing) *Recommend temperature be taken to confirm either way Temp:	?	11/1/	76 B
If Yes, what symptoms are they exhibiting?		pa =	
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Mothed of O		- 7 AL	
Method of Screening (Please Check the Appropriate Box Below):			
☐ In Person			
		N/A	N/A
By Phone			
NSTRUCTIONS:			-
For patients who respond "yes" to any of these questions:			
Cancel their appointment		1 f '	
Instruct them to contact their primary physician or public health deports	ment as soon as		
Page 10 determine il they should be seen or tested	nont as soon as		
If they are showing symptoms of a fever, cough, shortness of breath:			
o Give them a mask;			
o Advise them to contact their primary physician or public health	department as soon		
as possible. Before they go to a doctor's office or emergency tell them about their recent travel and symptoms;	room, call ahead and	10.11.60	4.
O Avoid contact with others:			
o Instruct them to cover their mouth and nose with a tissue or the	eir sloova (not their	į l	
o Instruct them to wash hands often with soan and water for 45	20 seconds. Use an		174
alcohol-based hand sanitizer with at least 60% alcohol if soap	and water are not		

*Scan the completed form into the patient's dental record

IMPORTANT - If this tool is used to screen a patient by phone prior to their arrival, please remind the patient of the following: Should they experience any signs of an illness before their appointment (i.e. fever, cough, or shortness of breath), they must call the office prior to coming to the office.



available.

Notes:

(Date)

N/A

N/A