AQUIDNECK AVENUE FAMILY DENTAL

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT 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 and how it relates to our dental practice.

1. I knowingly and willingly consent to dental treatment at Aquidneck Avenue Family Dental and to be treated by any designated associates or employees during the reopening phase of COVID-19.

2. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still contagious. It is difficult to determine who has COVID-19 and who does not given the current limitations and availability in COVID-19 viral testing.

3. I understand that due to the frequency of visits of other dental patients, characteristics of the virus, and the water-spray-generating characteristics of certain, select dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office; even though standard precautions are being observed, to the best of the office's ability, to minimize and mitigate these risk factors.

4. I am unaware of being a possible carrier or infected for COVID-19. I confirm that I have not tested positive for COVID-19 in the last 30 days and have completed the ***COVID-19 Patient Screening Form*** accurately and responsibly.

5. I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone who has had characteristic symptoms of COVID-19 (fever in excess of 100.4°, cough, shortness of breath, loss of taste/smell, etc...) in the past 14 days.

6. I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled outside of the state of Rhode Island (for non-work related purposes) by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT:

I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I understand and accept the potential risk of contracting COVID-19 during the time spent within this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and from environments and circumstances unrelated to my visit here. I voluntarily choose to receive dental care, be it emergent, urgent, time sensitive, preventive, elective, and/or consultatory in nature, and assume any and all medical/dental risks which may be associated with any phase of my treatment during the COVID-19 pandemic.

I have read and understand the information stated above:

Patient Name Patient/Guardian Signature Date