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**COVID-19 (Coronavirus) Pandemic Dental**

**Treatment Consent Form**

**I knowingly and willingly consent to have dental treatment completed during the COVID-19 Pandemic.**

**I understand the COVID-19 Virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious.**

**There are several modes of transmission of COVID-19 which could be present in a dental office. We are following the ADA and CDC guidelines to minimize the risk of transmission.**

* **I understand that due to the frequency of visits of other dental patients, the characteristics of virus, and the characteristics of dental procedures, that I have elevated risk of contracting the virus simply by being in a dental office. \_\_\_\_\_\_\_\_\_\_**

**(Initial)**

* **I confirm that I am not presenting any of the following symptoms:**
* **Fever**
* **Shortness of breath**
* **Dry Cough**
* **Runny Nose**
* **Sore Throat**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Initial)**

**I understand that air travel significantly increase my risk contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Initial)**

* **I verify that I have not traveled outside the United States in the Past 14 days**
* **I Verify that I have not traveled domestically within the United States by Commercial airline, bus, or train within the past 14 days**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Initial)**

**Have you had the the vaccine for Covid 19 Date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**