Implant and Sedation Dentistry of Charleston
Consent
For Dental Treatment during COVID-19 Outbreak

1. I, ____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic at Implant and Sedation Dentistry of Charleston.
2. I understand that carriers of the COVID-19 virus may not exhibit any symptoms, and if they do, the virus has a long incubation period of up to 14 days or longer before symptoms are apparent. Therefore, prior to confirmation of the infection with specific COVID-19 testing, it is impossible to determine who has been infected with and can transmit it to others. _______________ (Initials)
3. I understand that the CDC recommends social distancing of at least six (6) feet to reduce the transmission of the virus, and that this is impossible with dental treatment. ________________ (Initials)
4. Has anyone in your household been tested for COVID19 within the last four days? _____ **Yes** _____ **No**

I confirm that I am not presenting with any of the following symptoms listed here:

• Fever • Shortness of breath • Dry cough • Runny nose • Sore throat ______________ (Initials)

I understand that air travel as well as other forms of mass transit significantly increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have not traveled by commercial airline, bus, or train within the past 14 days. ________________ (Initials)

____ ________________

Name – Signature Date

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