

CONSENT FOR TREATMENT (COVID-19)

1. I knowingly and willingly consent to periodontal treatment by Dr. Ava Khodakhast any designated 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 highly contagious. It is impossible to determine who does and does not have COVID-19 given the current limitations and availability in COVID-19 viral testing.
3. **Risk of transmission:** I understand that due to the frequency of visits of other patients, characteristics of the virus, and the nature of periodontal 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.
4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 14 days and that I am not presenting with any of the following symptoms of COVID-19:
 - a. Fever of 100.5 degrees Fahrenheit (38 degrees Celsius) or higher
 - b. Shortness of breath
 - c. Dry cough
 - d. Runny nose
 - e. Sore throat.
 - f. Diminished sense of taste or smell
5. **Contact with infected:** 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 that has had the above stated symptoms in paragraph 4 in the last 14 days.
6. **Public travel:** I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

Patient's Printed Name

Signature of patient, legal guardian or authorized representative

Date