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. We have taken extensive safety precautions in addition to our standard precautions to limit the risk of virus transmission to both our staff and patients. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

I knowingly and willingly consent to dental treatment at Ted Loiben DDS Pediatric Dentist Ltd. by Dr. Loiben and any designated associates and employees during the reopening phase of COVID-19.

I understand that the COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office, even through the standard precautions are being observed.

I am unaware of myself or my child being a possible carrier or infected. I confirm that neither myself nor my child have tested positive for COVID-19 in last 30 days and that my child does not have any of the following symptoms: fever, shortness of breath, dry cough, runny nose, sore throat, diminished sense of taste or smell.

Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of 15 minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone who has had any of the above stated symptoms of COVID-19.

I confirm that I have read the notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that my child can contract the COVID-19 virus from outside the office and unrelated to my visit here. I voluntarily assume any and all medical/dental risks, including substantial and significant risk of serious harm, if any, which may be associated with my child's 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. I have read and understand the information stated above:

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Child's Name (Please Print) Parent's Name (Please Print)

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Signature of Caregiver/Responsible Party Witness