THE DENTAL
ANESTHESIA CENTER

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Novel Coronavirus (COVID-19) Treatment Disclosure

Patient Name: ______________________________

Patient Guardian Name: ______________________________

I have freely elected to proceed with all elective and emergent treatment and fully understand that proceeding with the treatment increases my risk/my child's risk of exposure to and/or contraction of community acquired Novel Coronavirus (COVID-19) infection. Acquiring such infection can lead to severe symptoms such as fever, chest pain, shortness of breath and further respiratory complications leading to:

- Prolonged Hospitalization
- Intensive Care Unit Admission
- Intubation with Mechanical Ventilation
- Possible Death

I also affirm that neither I/my child, nor any family members that I have been in close contact with have been exposed to or had any of the following symptoms in the past 14 days (2 weeks):

- Shortness of Breath
- Chest Pain
- Fever
- Fatigue/Body Aches
- Confirmed or Suspected Novel Coronavirus (COVID-19) infection

I, hereby consent, to proceeding with my/my child's procedure and have a full understanding of the risks and alternatives to treatment. All of my questions regarding treatment at this time have been answered to my satisfaction by my dentist anesthesiologist at The Dental Anesthesia Center.

Patient/Guardian Signature: ______________________ Date: __________

Relationship to Patient: ______________________