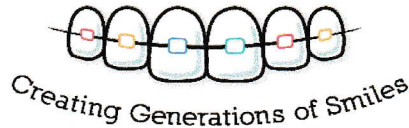


Orthodontic Associates of Collegeville, P.C.

Adam J. Weiss, D.M.D.

Orthodontics for Children & Adults



COVID-19 Pandemic Emergency Dental Treatment
Consent Form

I, _____, (Print Name of Patient or Parent if Minor) knowingly and willingly consent to have emergency dental treatment completed for me or my child _____ (Print Name of Patient) 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. It is impossible to determine who has it and who does not give the current limits in virus testing. Dental procedures create water spray which is how the disease is spread. The ultra- fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____
(Initials of Patient or Parent if Minor)

I have been made aware of the CDC, OSHA, and ADA, guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months.
_____(Initials of Patient or Parent if Minor)

I confirm I am seeking treatment for a condition that meets these criteria. _____(Initials of Patient or Parent if Minor)

I confirm I am not presenting any of the following symptoms of COVID-19 listed below:

Fever

Shortness of Breath

Dry Cough

Runny Nose

Sore Throat

_____(Initials of Patient or Parent if Minor)

I understand that air travel significantly increases my risk of 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. _____(Initials of Patient or Parent if Minor)

I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19.
_____(Initials of Patient or Parent if Minor)

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____(Initials of Patient or Parent if Minor)

Printed Name _____

Date _____

Signature _____
(Signature of Patient or Parent if Minor)

555 Second Avenue, Ste E-202, Collegeville, PA 19426 610-409-9880
www.orthodontiststs.com