CENTRAL COAST Smiles

Guy Alexander Jones, DDS

Covid -19 Pandemic Dental Consent **TEMP: _____**

I,_____, knowingly and willing consent to have dental treatment completed for myself or minor child_____during the COVID-19 pandemic. I will hold harmless and indemnify Dr. Guy Jones, the practice and all employees against any claims and actions in exchange for dental treatment during the events of COVID-19.

- I understand the characteristics of both the virus and dental procedures increases the risk of contracting the virus simply by being in thedental office.
- I understand travel significantly increases my risk of contracting and transmitting COVID-19 virus. I verify that I have NOT travelled outside the United States, nor travelled domestically within the United States within the past 14 days.
- I confirm that I am NOT presenting any of the following symptoms presently nor in the last 14 days: **Please initial each item**

Date:_____OR the past 14-21 days

	NO	YES
* Fever	_____	_____
* Shortness of Breath	_____	_____
* Dry Cough	_____	_____
* Runny Nose	_____	_____
* Sore Throat	_____	_____
* Loss of taste/smell	_____	_____
* Flu-Like Symptoms	_____	_____

- No one in my household has had any of the above issues/symptoms in past 14-21 days

- I have not knowingly been in contact with any confirmed cases of COVID-19positive patients.

I,_____, make this decision of my own free will relying upon my knowledge and judgement of any possible transmission of COVID-19 during treatment and my decision to release has not been affected by any false statements. I have carefully read this release and understand its contents, and I am signing it of my own free act.

Signature/Guardian:_____Date:_____