

### Consent to treatment during COVID-19 Pandemic

You are receiving dental care during the events of a COVID-19 National Emergency. Please be advised that there may be risks in being in the proximity of dentists, patients, or staff. We are taking precautions to limit the spread of disease, yet there is still a possibility of transmission.

By my signature below I am acknowledging that I understand the risk and am accepting it.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient/Parent/Legal Guardian