JUANITA FAMILY DENTISTRY
13611 100th Ave NE
Kirkland, WA 98034
425.821.3388

COVID-19 DENTAL TREATMENT CONSENT FORM

PATIENT NAME _____

CONTACT NUMBER _____

Do you or have you had a fever of above 100.4° in the past 14 days?	NO	YES
Have you recently lost or had a reduction in your sense of smell or taste?	NO	YES
Are you having shortness of breath or trouble breathing?	NO	YES
Do you have a cough?	NO	YES
Do you have other flu-like symptoms; such as gastrointestinal upset, headaches, or fatigue?	NO	YES
Have you been in contact with someone who has tested positive for or suspected they were positive for COVID-19 (corona virus) in the last two weeks?	NO	YES
Have you tested positive for COVID-19 or are you awaiting test results for COVID-19 within the last 10 days?	NO	YES
Do you have a compromised immune system in any way?	NO	YES
Are you over 60 years of age?	NO	YES

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources.

The COVID-19 virus has a long incubation period. While our team goes through daily temperature checks and a health screening questionnaire, determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing at this time.

For this reason there is some risk associated with receiving treatment or being in any public setting at this time. We are complying with and going beyond all safety protocols put forth by the Washington State Department of Health and our advisory board to mitigate this risk and make our office environment as safe as possible. However, we can make no guarantee of a completely risk free environment.

I confirm that I have read the Notice above and understand the content. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here at any time**.**

By signing below I accept the above and wish to continue with my dental care.

PATIENT SIGNATURE _____ **DATE** _____