Beachwood Smiles
24300 Chagrin Blvd., Suite 306
Beachwood, Oh 44122
(216) 292-9920

COVID-19 Pandemic
Dental Treatment Consent Form

Even after following protocols set by the American Dental Association and our state's dental association, it is still possible to contract COVID-19 while at a dental office. We are following all guidelines to minimize the risk of transmission.

• I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. _____ (Initial)

• I understand that due to the frequency of visits of other dental patients, the characteristics of the COVID-19 virus, and the characteristics of dental procedures I have an elevated risk of contracting the COVID-19 virus simply by being in a dental office. _____ (Initial)

• I confirm that I am not presenting any of these COVID-19 symptoms: _____ (Initial)
o Fever o Shortness of breath o Sore throat o Dry cough o Runny nose

• I confirm that I have not been in contact with a person who has been diagnosed with COVID19 within the past 14 days. _____ (Initial)

• 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 six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with dentistry. _____ (Initial)

• I verify that I have not traveled outside the United States in the past 14 days. _____ (Initial)

• I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days. _____ (Initial)

I understand that a $35 Covid-19 Protocols Fee is due for my visit today, dependent on the current market value and type of PPE required for your treatment.
I irrevocably request that I pay directly for the Covid-19 Protocols Fee and that it not be reported to the insurance company as allowed under the HIPPA patient privacy act. _____ (Initial)

Printed name: _____ Date of birth: _____

Signature: _____ Today's date: _____