**Dental Treatment Consent Form**

**COVID-19 Pandemic**

1. The undersigned patient (the “Patient”) knowingly and willingly consents to dental treatment by dentists, hygienists, technicians, and other employees of Manik R. Khisti, DMD, PLLC (the “Practice”) during the COVID-19 pandemic.

1. I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms, yet are still highly contagious. It is impossible to determine who carries the virus based on current limitations and availability of COVID-19 viral testing.
2. I understand that I may not be treated by the Practice if I have the COVID-19 virus or if I have been in contact with someone who has the COVID-19 virus. Therefore, I represent the following:

A. I am unaware of any close contact with anyone who has or had the COVID-19 virus;

B. I have not tested positive for COVID-19;

C. I have not travelled outside the United States within the past 14 days, and I have not travelled domestically using public mass transportation, such as commercial airline, train or bus;

C. I am not currently presenting with any of the following symptoms of COVID-19, and I have not had any of the following symptoms within the last 14 days:

i. Fever of 100.5 degrees Fahrenheit or 37 degrees Celcius or higher;

ii. Shortness of breath;

iii. Dry cough;

iv. Runny nose;

v. Sore throat;

vi. Diminished sense of taste and/or smell.

1. I understand that the Practice is providing its best efforts to follow CDC, OSHA, ADA, Virginia Department of Health and other professional guidelines for operation of the Practice, but that due to the nature of dental procedures, the risk of COVID-19 transmission cannot be eliminated. Dental procedures involve close personal contact and often create fine water spray, which may linger in the air for an indefinite time after a procedure. The Practice may have treated patients on an emergency basis without full screening, and other high-risk patients may have been treated by the Practice despite screening procedures. All of these factors create risk of COVID-19 transmission. Therefore, I understand that I have a higher risk of contracting COVID-19 simply by being in a dental office.

**INFORMED CONSENT: I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been fully explained to me, and I have been given the opportunity to ask questions. I do voluntarily assume any and all reasonable medical/dental risks involved with my dental treatment during the COVID-19 pandemic, including the substantial and significant risk of serious harm, injury, illness, or even death.**

Patient Printed Name Signature of patient/legal guardian/ Date

Authorized Representative

Witness Date