Office Anesthesiology & Dental Consultants, PC

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COVID-19 (Corona Virus) Disclosure

Patient Name: _____

Parent Guardian Name: _____

The Illinois State Dental Society and the Indiana Dental Association have both allowed the resumption of elective oral health care.
I hereby affirm that my dentist/surgeon and Office Anesthesiology & Dental Consultants, PC have offered me the opportunity to reschedule dental treatment under general anesthesia to a subsequent date if I so desired. I also affirm that I have, freely, elected to proceed with the procedure due to pain/infection that are unmanageable at home with medications. I have consulted the treating dentist for other alternatives and have been advised to consult the primary care physician as well.
I fully understand that proceeding with the treatment today increases my exposure/my child's exposure to the risk of contracting community acquired COVID 19 (Corona Virus) infection.
Acquiring such infection can lead to severe symptoms such as fever, chest pain, shortness of breath and further respiratory complications. Advanced disease can also lead to:

1) Prolonged hospitalization.
2) Intensive care admission.
3) Mechanical ventilation.
4) Possible death.

I also affirm that neither I/My Child, nor any of my family members have been exposed to any of the following symptoms in the past 14 days:

1) Shortness of breath.
2) Chest pain.
3) Fever.
4) Fatigue and body aching.
5) Confirmed or suspected COVID 19 (Corona Virus) infection.

I am consenting to this procedure with full understanding and disclosure of such risks and alternatives, and all my questions were answered to my satisfaction.

Patient Signature: _____ Date: _____

Relationship to Patient: _____

Dentist/Surgeon: _____ Date: _____

Witness: _____ Date: _____