Amidi Dental
Family & Cosmetic Dentistry
1039 El Monte Ave., #E • Mountain View, CA 94040 • (650) 988-6500

COVID-19 Essential Treatment Consent Form

I, _____ (the patient), consent to receive essential dental treatment from Amidi Family and Cosmetic Dentistry during the COVID-19 outbreak.

I understand there is much to learn about the newly-emerged COVID-19, including how it spreads and is transmitted.

I understand that based on what is currently known about COVID-19, the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious. I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in and receiving treatment in the practice.

I understand that under the Center for Disease Control and Prevention (CDC) and American Dental Association (ADA) guidelines, non-essential treatment is not recommended at this time.

I understand that the treatment I am receiving is essential because I may lose this tooth/teeth if the treatment is not rendered in a timely manner. I confirm I am seeking treatment for a condition that meets these criteria. ____ (Initial)

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry cough
- Shortness of breath
- Temperature
- Persistent pain or pressure in the chest
- Loss of taste and smell

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above: _____ (Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____ (Initial)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. _____- (Initial)

Patient Name:_____

Patient/Guardian Signature:_____
Date:_____

For Practice Use:

Doctor Signature:_____

Date:_____