**Wake Dental Care - COVID-19 Consent**

Currently there is some increased risk associated with in-office evaluation and treatment during the COVID pandemic. These risks include:

• Exposure to other patients

• Exposure to healthcare staff

• Exposure to healthcare facilities

Patients in the following categories and with the following health conditions are at greater risk:

• Asthma

• Chronic lung disease

• Diabetes

• Serious heart disease/conditions

• Chronic kidney disease

• Severe obesity

• Age 65 or older

• Nursing home or long-term care facility residents

• Immunocompromised or immune suppressed patients

• Liver disease

• Pregnancy

If you have one or more of these problems, you may be at greater risk for contracting COVID. If you contract COVID, you may be at greater risk to develop complications, including serious complications, possibly leading to hospitalization and, in rare situations, death.

**Alternative Evaluation and Treatment Choices**

There are alternative means of evaluation and treatment that may be appropriate for you. These alternatives include:

• Phone evaluation

• Telehealth/Teledentistry evaluation via video

These alternatives may or may not be appropriate for you depending on your specific problem and underlying health conditions. If remote assessment and treatment are not sufficient, your doctor will attempt to answer questions and explain why an in-office evaluation is recommended in your circumstance.

**More Facts**

Medical staff and office personnel may help your doctor during intake, evaluation and treatment. They will follow state laws and current recommendations from local, state and national health officials related to screening patients for alternative means of evaluation and performance of in-office assessments and care. Although we are taking steps to reduce risks, we cannot completely eliminate these risks, especially for higher risk patients.

**Consent to Treatment**

\_\_\_\_\_\_\_\_\_\_\_\_ (initial) The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you do not believe that you really understand the risks and choices, do not sign the form until all questions have been answered.

\_\_\_\_\_\_\_\_\_\_\_\_ (initial) I understand the facts provided to me on the first page of this consent form. I give my consent for in-office evaluation and treatment. By signing below, I agree that staff/doctor has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions, and that all of my questions have been answered.

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Patient Name (Print)

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Signature of Patient (or Responsible Party) Date

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Relationship to Patient (if Responsible Party is not Patient)

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Witness Date