NOVA DENTAL PARTNERS
COVID-19 PANDEMIC PATIENT DISCLOSURE

This patient disclosure form seeks information from you that Nova Dental Partners must consider before making treatment decisions in the circumstance of the COVID-19, also known as "Coronavirus," pandemic.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. **Please disclose to us any condition that compromises your immune system and understand that such disclosures may impact treatment decisions.**

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. These symptoms may appear 2-14 days after exposure to the virus. It is important that you disclose any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

COVID-19 DISCLOSURE QUESTIONS	Yes	No
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a cough, runny nose, or sore throat?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Have you experienced chills or repeated shaking with chills?	☐	☐
Do you have muscle pain?	☐	☐
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐	☐
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐	☐

I fully understand and acknowledge the above information, risks and cautions and have disclosed to Nova Dental Partners any other conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

______________________________ ______________________

Patient or Legal Representative Signature **Date**

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Print Patient or Legal Representative Name/Relationship

NOVA DENTAL PARTNERS
CONSENT FOR DENTAL TREATMENT
COVID-19 WAIVER

I, ____, understand that there is presently a public health emergency as declared by the President of the United States and the Governor of this State. I understand that being in public and/or receiving dental treatment at this time may present an increased risk of the transmission and/or the contraction of COVID-19. While Nova Dental Partners will take the necessary precautions in order to reduce the risk of transmission of COVID-19 during any dental treatment and/or procedure, at this time there is no way to guarantee such procedure and/or treatment will be completely risk free.

I hereby knowingly and freely acknowledge, and assume any and all risks, known and unknown, related to the potential contraction of COVID-19 during the dental procedure and/or treatment, and assume full responsibility for such risk. I hereby agree to indemnify and hold harmless Nova Dental Partners, its employees, officers, owners, doctors, directors, members, managers, members, contractors, agents and/or representative from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, which may be brought as a result of the dental procedures and/or treatment provided on the date identified below or hereafter as such treatment and/or procedure may be related to the contraction of COVID-19.

_________**(Initial)**

I understand that while my Provider may take the necessary precautions in order to reduce the risk of COVID-19 transmission during any dental treatment and/or procedure that I may receive, at this time due to the presence of other dental patients, the nature and characteristics of the virus, and the nature and methods of dental procedures, there is no way to guarantee any procedure and/or treatment will be completely risk free. I hereby acknowledge that I may have an elevated risk of contracting the COVID-19 virus by being in a dental office.

_________ **(Initial)**

I understand that the CDC recommends social distancing of at least 6 feet and that this is not possible during any dental treatment and/or procedure.

_________**(Initial)**

I verify that I have not traveled internationally or domestically by commercial airline, bus, or train within the past 14 days.

_________**(Initial)**

The undersigned, on behalf of myself as well as any of my heirs, personal representative or assign, hereby release, waive, discharge, and covenant not to sue Nova Dental Partners, or any of the Nova Dental Partners employees, officers, owners, doctors, directors, members, managers, contractors, agents, and/or representatives for any and all claims, known or unknown, which may be related to the transmission and/or contraction of COVID-19, including but not limited to claims which may result in personal injury, illnesses (including death), loss of income or other property loss.

_________**(Initial)**

I have read this document and discussed all of the above with the Nova Dental Partners, and all my questions have been answered to my satisfaction.

Following the explanation, the discussion, and the answers to my questions, I authorize the Nova Dental Partners to complete the treatment as described.

_______________________ _____________________ _________________________________

Patient/Guardian Signature **Date**

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Print Patient Name