COVID-19 Dental Treatment Consent Form

I, _____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures create water spray which is how the disease is spread. The ultra-fine natural of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

1. I confirm I am not presenting any of the following symptoms of COVID-19 listed below:
    - Fever or chills
    - New loss of taste or smell
    - Flu like symptoms

2. Have you been fully vaccinated against COVID-19?

    ☐ Yes

    ☐ No

    ☐ Prefer not to answer

3. Are you self-inoculated from having COVID-19?

    ☐ Yes

    ☐ No

    ☐ Prefer not to answer

Signature: _____

Patient Name: _____

Date: _____

SPRING LAKE DENTAL CARE
DR. PETER CIAMPI AND ASSOCIATES

PERIODONTAL RECARE APPOINTMENT UPDATE

Would you please take few moments and answer the following questions? Thank you.

Please Circle

1. Name:_____
2. Any change in address or phone? _____ YES NO
   a. Cell phone is:_____
   b. Email is: _____
3. Any changes in your dental benefits?_____ YES NO
   _____
4. Are you presently having a dental problem? Please explain. _____ YES NO
   _____
5. Has your medical history changed since your last dental visit? Please explain. __ YES NO
   _____
6. Do you have any allergies? Please list:_____ YES NO
   _____
7. Are you taking any medications or Herbal Supplements? Please list:_____ YES NO
   _____
   _____
8. On a scale of 1 to 10, how would you rate your smile? _____
9. Would you like information about having whiter or straighter teeth? YES NO

Missed or cancelled appointments within (2) business days may be subjected to a charge at the rate of $450/hr for dentist and $155/hr for hygienist.

Patient Signature **Date**

Doctor Signature **Date**