

Toothman Dental Group, LLC
1920 Bethel Rd
Columbus, OH 43220

COVID-19 Informed Consent

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so. Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness at our office, just as you might be at your gym, grocery store, or favorite restaurant.

- I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. _____(Initial)
- I confirm that I am not awaiting the results of a COVID-19 test. _____(Initial)
- I confirm that I am not presenting any of these COVID-19 symptoms: _____(Initial)
 - Fever
 - Shortness of breath
 - Dry cough
 - Runny nose
 - Sore throat
- I confirm that I have not knowingly been in contact with a person who has been diagnosed with COVID-19 within the past 14 days. _____(Initial)
- Temperature taken today was _____ degrees by _____ (staff member initials).

Printed name: _____
(Patient)

Date of Birth: _____
(Patient)

Signature: _____
(Patient or legal guardian)

Today's date: _____