OREGON FAMILY DENTISTRY
696 JANESVILLE ST
OREGON, WI 53575
608-835-0103

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OR RISK FORM

Our goal is to provide a safe environment for our patients and staff and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-9 VIRUS.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care. The COVID-19 virus has a long incubation period. You or your healthcare provider may have the virus and not show any symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited accuracy and availability of virus testing.

Due to the frequency and timing of the virus by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in the dental office.

Dental procedures create water spray which is one of the way the disease is spread. The ultra-fine nature of the water spray can linger in the air for an unknown period of time, allowing for transmission of the COVID-19 virus to those nearby. You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need to access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside the office unrelated to my visit here. **I understand that in order to receive treatment at Oregon Family Dentistry, I must accept the risk outlined in this document.**

Patient Signature: _____

Date:_____

Witness:_____