COVID-19 Disclosure, Screening, and Consent

This patient disclosure form seeks information from you that we must consider before making treatment decisions during the COVID-19 virus outbreak.

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 we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

*** Do you or the patient have a fever or have felt hot or feverish within the last 14-21 days?**

○ Yes ◉ No

*** Do you or the patient have shortness of breath or other difficulties breathing?**

○ Yes ◉ No

*** Do you or the patient have a cough and/or sore throat?**

○ Yes ◉ No

*** Do you or the patient have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?**

○ Yes ◉ No

*Have you or the patient experienced recent loss of taste or smell?

○ Yes ◉ No

*Have you or the patient been in contact with any confirmed COVID-19 positive patients in the last 21 days?

○ Yes ◉ No

*Have you or the patient been tested for COVID-19 and are awaiting results or tested positive for COVID-19 in the last 21 days?

○ Yes ◉ No

*Have you or the patient traveled in the past 14 days to any regions affected by COVID-19?

○ Yes ◉ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment. For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

1. I knowingly and willingly consent to dental treatment at Elite Dental Center by Drs. Eckhardt, Isom and/or Rusch, and any designated associates and employees during the reopening phase of COVID-19.

2. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has COVID-19 and who does not, given the current limitations and availability in COVID-19 viral testing.

3. Risk of transmission: I understand that due to the frequency of visits of other care dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though standard precautions are being observed.

4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:

A. Fever of 100.4 degrees Fahrenheit or 37 degrees Celsius or higher

B. Shortness of breath

C. Dry cough

D. Runny nose

E. Sore throat.

F. Diminished sense of taste or smell

5. Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above-stated symptoms in paragraph 4 (#4) in the last 14 days.

6. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

Patient name: Harry Mills

Signed By: Harry Mills

Date: 2/1/2022

By signing below, you are consenting to the use of a digital signature

Patient or Guardian's Signature

Consent for Scaling and Root Planing

I understand that periodontal procedures (treatment involving the gum tissues and other tissues supporting the teeth) include risks and possible unsuccessful results from such treatment. Even though the utmost care and diligence will be exercised in the treatment of periodontal disease and associated conditions through scaling and root planning and related procedures, there are no promises or guarantees as to anticipate results. I agree to assume those risks and possible unsuccessful results associated with, but not limited to the following:

1. Response to treatment: Because of many variables within each patient's physiological make-up, it is impossible to precisely determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by both the provider and the patient. Should the desired results not be attained, extractions may be required.

2. Postoperative patient responsibility for care: With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment, as instructed by the treating dentist. Without the necessary follow-up care by the patient, the probability of unsatisfactory results is greatly increased.

3. Pain, soreness and sensitivity: There may be post-operative discomfort which may be transitory or permanent, related to hot and cold stimuli, contact with teeth, and sweet and sour foods. The gums will also be sore immediately following treatment.

4. Bleeding during or after treatment: Laceration or tearing of the gums may occur which might require suturing. The gums may bleed as well during or after treatment.

5. Recession of the gums after treatment: After healing occurs, there may be gum recession which exposes the margin or edge of crowns or fillings, increases sensitivity of teeth, creates esthetic or cosmetic changes in front teeth which results in longer teeth and wider interproximal spaces visible as a black triangle. These wider interproximal spaces are more likely to trap food.

6. Broken curettes, scalers or other instruments, and post-treatment infection: It may be necessary to retrieve broken instruments surgically. Post treatment infection may also result from calculus being lodged in the tissue which may also require surgical intervention.

7. Increased mobility (looseness) of the teeth during the healing period

8. Noise and water spray: Ultrasonic instrumentation is noisy and the water used may cause cold sensitivity during treatment on un-anesthetized teeth in the treatment field.

9. Post-treatment complications: Cracking or stretching of the lips/corners of the mouth during treatment is possible. There is the possibility that additional surgical treatment may be necessary after root planning.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible problems and risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I freely give my consent to allow and authorize the doctor and/or his/her associates to render the dental treatment necessary or advisable to my dental condition(s), including administering and prescribing all anesthetics and/or medications.

Patient name: Harry Mills

Signed By: Harry Mills

Date: 2/1/2022

Teeth or quadrants: LL, UL

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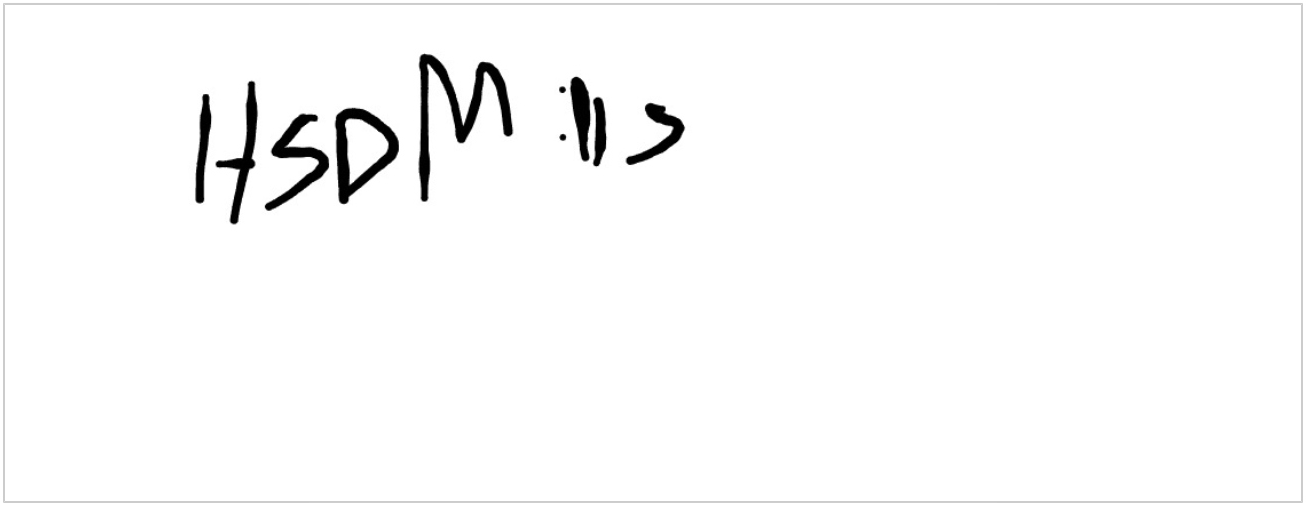

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