Patient Treatment Consent and Release of Claims Form

I,_____(**the patient**), consent to receive dental treatment from Cyndi Chen DDS Inc. (the "Practice") during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the Practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the Practice and by receiving treatment in the Practice.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry cough
- Shortness of breath or difficulty breathing
- Chills
- Reseated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste and/or smell
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I, and those who live with me, have not displayed, or currently have, any of the symptoms that are representative of COVID-19, which are outlined above. _____(**Initial**)

I confirm that, to the best of my knowledge, in the past 14 days I have not come into close contact with anyone who appeared to me as displaying, or having, any of the symptoms that are representative of COVID-19, which are outlined above. _____(**Initial**)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days._____(**Initial**)

I understand that all travelers arriving from a country or region with widespread ongoing transmissions should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I, and those who live with me, have not returned in the last 14 days from traveling to any of the countries or regions with widespread ongoing transmissions, including all European countries, China, Korea, and Latin America._____(**Initial**)

I understand that the CDC recommends social distancing of at least 6 feet to any individual not living in your household, and this is not possible with dentistry. _____ (**Initial**)

I confirm that if I test positive or advised presumptive positive by a medical professional within 14 days of receiving treatment, I will immediately notify the Practice. _____ (**Initial**)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19, and I and my close family have practiced social/physical distancing in the past 14 or more days_____(**Initial**)

RELEASE OF CLAIMS

I release, that is, I give up and forever relinquish any and all claims, complaints and any legal actions in any court of law, or in any other proceedings before any governmental entity, that I became infected with COVID-19, or that I suffered any other personal, physical or any other injury as a result of the dental treatment I have received from the Practice and from all the professional and technical providers who treated me at the Practice. I understand this release means that I can never bring any claim for any money damages, nor for any other legal remedy/relief against the Practice and any of the professional and technical providers at the Practice.

I acknowledge that I have read and understand this Release and that I knowingly and voluntarily have signed it as a condition of the Practice agreeing to provide dental treatment for me.

Patient Name (Print):_____

Patient/Guardian Signature:_____

Date:_____

For Practice Use:

Doctor Signature:_____

Date:_____