COVID-19 Treatment Consent Form

I, _____(the patient or legal guardian of), consent to receive treatment from **Peluso Orthodontics** during the COVID-19 outbreak along with a forehead (with barrier protection) temperature read.

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

- Fever-Temperature upon arrival: _____
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above: _____(Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival. I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____ (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)

Patient Name:_____
Patient/Guardian Signature:_____
Date:_____

For Practice Use:
Doctor Signature:_____
Date:_____