

Granite Peak Orthodontics

Dr. Aaron McDonough

1221 S Higgins Ave, Missoula, MT 59801

**COVID-19 Pandemic  
Dental (Orthodontic) Treatment Consent Form**

Even after following protocols set by the American Dental Association and our state’s dental association, it is still possible to contract COVID-19 while at a dental (orthodontic) office. We are following all guidelines to minimize the risk of transmission.

* I knowingly and willingly consent to have dental (orthodontic) 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 understand that – due to the frequency of visits of other dental (orthodontic) patients, the characteristics of the COVID-19 virus, and the characteristics of dental (orthodontic) procedures – I have an elevated risk of contracting the COVID-19 virus simply by being in a dental (orthodontic) office. \_\_\_\_\_\_\_ (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 been in contact with a person who has been diagnosed with COVID19 within the past 14 days. \_\_\_\_\_\_\_ (Initial)
* I understand that air travel significantly increases my risk of contracting and transmitting the   
  COVID-19 virus. And the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with dentistry (orthodontics). \_\_\_\_\_\_\_ (Initial)
* I verify that I have not traveled outside the United States in the past 14 days. \_\_\_\_\_\_\_ (Initial)
* I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days. \_\_\_\_\_\_\_ (Initial)

Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient) (Patient)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient or legal guardian)