DR. CHARLES TOWE, JR.
FAMILY + COSMETIC DENTISTRY

4334 NW EXPRESSWAY ▪ STE 291
OKLAHOMA CITY, OK 73116

405.848.8745

CONSENT FORM

FOR DENTAL TREATMENT DURING COVID-19 PANDEMIC

I, _____, consent to have my dental treatment done during this time when there are still unknowns about the incubation period, symptoms, as well as virus transmission.

I understand that Dr. Towe and his team follow proper infection control procedures to minimize the possibility of any disease.

Dr. Towe does NOT allow any staff members who think they have been exposed or who feel sick with fever to be in the office.

- I confirm that I am not presenting any of the following symptoms of Covid-19 listed below:
  - FEVER
  - DRY COUGH
  - SORE THROAT
  - SHORTNESS OF BREATH
  - RUNNY NOSE
  - _____ *(initial)*
- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by Covid-19. _____ *(initial)*
- I verify that I have not traveled domestically within the United States by commercial airlines, bus or train within the past 14 days. _____ *(initial)*

Please be sure to notify our office of any signs or symptoms of Covid-19 in the next 14 days.

Ask Dr. Towe any questions if you have any concerns. We are here to meet your dental treatment needs.

Name: _____
Date: _____
Witness: _____

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PATIENT SCREENING FORM

FOR DENTAL TREATMENT
DURING COVID-19 PANDEMIC

	PRE-APPOINTMENT	IN-OFFICE
Do you have fever or have you felt hot or feverish recently? (14-21 days)	☐ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatique?	☐ Yes ☐ No	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you in contact with any confirmed Covid-19 positive individuals? *People who are well but who have a sick family member at home with Covid-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled in the past 14 days to any regions affected by Covid-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with the elective dental treatment.