Jungle Roots
Children's Dentistry & Orthodontics

COVID-19 Pandemic – Patient Disclosures

This patient disclosure form seeks information from your family/household that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

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 child's (or 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 our office any indication of having been exposed to COVID-19 or any other virus, or whether you have experienced any signs or symptoms associated with the COVID-19 virus or any other virus.

Please answer each line for your family/household:	YES	NO
Does anyone in the household have a fever, a dry cough, a sore throat, experienced shortness of breath, lost their sense of taste or smell?		
Does anyone in the household have asthma or respiratory concerns, Type 1 or 2 diabetes, autoimmune disease, is immunocompromised, is being treated for cancer, or undergoing treatment for kidney disease?		
Has anyone in the household been in contact with someone who has tested positive for COVID-19 in the last 2 weeks?		
Has anyone in the household been tested for COVID-19 and are awaiting results? When did you last experience symptoms?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.
By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature of Patient/Guardian: _____ Date: _____

We Are Committed To Your Safety

We are committed to staying open so your family can receive all necessary care, we will need to continue to charge a PPE fee.

The PPE fee is $15 per patient or $25 per family. This fee will be collected at each visit.

Signature of Patient/Guardian: _____

We appreciate your understanding and look forward to providing the safest and best patient care to your family.

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COVID-19 Pandemic Dental Treatment Notice and Acknowledgement of Risk Form

Parent/Guardian Temperature: _____ Parent/Guardian Temperature: _____ Initial: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of the dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

The patient cannot wear a protective mask over their mouth to prevent infection during treatment as the health care providers need access to their mouth to render care. This leaves the patient vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with the dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at our office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

Signature of Patient/Guardian: _____ Date: _____

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