**SUPPLEMENTAL INFORMED CONSENT in the Era of Covid 19**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,(Patient Name) consent to receive dental treatment from Dr. Martin Hikido DDS and/or Dr. Joanne Low 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 despite our careful attention and adherence to CDC guidelines with regard to sterilization, disinfection, and use of personal barriers there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the dentist, dental staff, and sometimes other patients at all times.

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

●Temperature

 ●Persistent pain or pressure in the chest

●Bluish lips or face

I confirm that I do not currently display or have had any of the symptoms in the last 14 days that are representative of COVID-19, 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 outside of our local area or outside the US 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:\_\_\_\_\_\_\_\_\_\_