SUPPLEMENTAL INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention 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. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. 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 patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ Yes ☐ No

_____

Patient Name

_____ _____

Parent/Guardian Name *(if applicable)* Relation

_____ _____

Patient/Parent/Guardian Signature Date

American Association of Orthodontists®

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SUPPLEMENTAL HEALTH QUESTIONNAIRE

Orthodontic Treatment in the Era of COVID-19

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Do you, your child, others accompanying you today or anyone else you have recently been in contact with have any of the following symptoms?

- **Fever** ***(defined as above 100.4° F degrees)*****?** ☐ Yes ☐ No
- **Chills?** ☐ Yes ☐ No
- **Cough?** ☐ Yes ☐ No
- **Sore Throat?** ☐ Yes ☐ No
- **Shortness of breath and/or trouble breathing?** ☐ Yes ☐ No
- **Persistent muscle pain, pressure or tightness in the chest?** ☐ Yes ☐ No
- **New loss of taste or smell?** ☐ Yes ☐ No

Have you or others accompanying you to today's appointment traveled outside of our local area or outside of the US within the past 14 days? ☐ Yes ☐ No

Have you, your child, others accompanying you today or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease? ☐ Yes ☐ No

If yes provide approximate dates of illness _____ through _____
(symptom start date) (symptom end date)

☐ I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's orthodontic appointment to a later date.

_____
Patient Name

_____ _____
Parent/Guardian Name *(if applicable)* Relation

_____ _____
Patient/Parent/Guardian Signature Date

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