CONSENT FOR ELECTIVE DENTAL TREATMENT
COVID-19 WAIVER
INDIVIDUAL

The undersigned does hereby acknowledge and agree that I have been informed by **David Cooney, DMD, PC** (hereinafter "Provider") of the need for me to undergo dental treatment as presented to me on the date indicated below.

I have been fully informed about the details of the recommended treatment and alternatives, and agree to accept the treatment as recommended by the Provider. I understand that as the treatment proceeds, there may be a need to change the treatment plan and/or procedure(s). If this occurs, every effort will be made by the Provider to keep me informed of any change prior to it being instituted, or as soon as practical thereafter.

I further understand that individual reactions to treatment and/or procedures cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment and/or procedure, I agree to report them to the Provider as soon as possible. I understand that the success of the recommended treatment and/or procedure depends upon my cooperation in keeping scheduled appointments, following home care instructions, including oral hygiene and dietary instructions, and reporting to the Provider any change in my health status as soon as possible.

I understand that during treatment it may be necessary to change and/or add procedures because of conditions that may be discovered during my treatment and/or procedure that were not discovered during examination. I hereby consent for the Provider to make any and all changes, and additions to my treatment and/or procedure as the Provider(s) may deem medically necessary.

I understand that there is presently a public health emergency as declared by the President of the United States and the Governor of this State. I understand that being in public and/or receiving dental treatment at this time may present an increased risk of the transmission and/or the contraction of COVID-19. While the Provider will take the necessary precautions in order to reduce the risk of transmission of COVID-19 during any dental treatment and/or procedure, at this time there is no way to guaranty such procedure and/or treatment will be completely risk free.

I hereby knowingly and freely acknowledge, and assume any and all risks, known and unknown, related to the potential contraction of COVID-19 during the dental procedure and/or treatment, and assume full responsibility for such risk. I hereby agree to indemnify and hold harmless the Provider, its employees, officers, owners, doctors, directors, members, managers, members, contractors, agents and/or representative from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, which may be brought as a result of the dental procedures and/or treatment provided on the date identified below or hereafter as such treatment and/or procedure may be related to the contraction of COVID-19. _____ (Initial)

I understand that while my Provider may take the necessary precautions in order to reduce the risk of COVID-19 transmission during any dental treatment and/or procedure that I may receive, at this time due to the presence of other dental patients, the nature and characteristics of the virus, and the nature and methods of dental procedures, there is no way to guaranty any procedure and/or treatment will be completely risk free. I hereby acknowledge that I may have an elevated risk of contracting the COVID-19 virus by being in a dental office. _____ (Initial)

I confirm that I do not have any of the following symptoms: Fever, Shortness of Breath, Dry Cough, Runny Nose, Sore Throat. _____ (Initial)

I understand that the CDC recommends social distancing of at least 6 feet, and that this is not possible during any dental treatment and/or procedure. _____ (Initial)

I verify that I have not traveled internationally or domestically by commercial airline, bus, or train within the past 14 days. _____ (Initial)

The undersigned, on behalf of myself as well as any of my heirs, personal representative or assign, hereby release, waive, discharge, and covenant not to sue the Provider, or any of the Provider's employees, officers, owners, doctors, directors, members, managers, contractors, agents, and/or representatives for any and all claims, known or unknown, which may be related to the transmission and/or contraction of COVID-19, including but not limited to claims which may result in personal injury, illnesses (including death), loss of income or other property loss. _____ (Initial)

I have read this document and discussed all of the above with the Provider, and all my questions have been answered to my satisfaction.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Following the explanation, the discussion, and the answers to my questions, I authorize the Provider to complete the treatment as described.

_____ _____
Patient's Signature Print Patient Name

_____
Witness Signature

_____
Date of Treatment