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®

CLEAR FORM

COVID-19 Patient Screening Form

Date: _____

Patient Name: _____

Patient's Temperature below 99 degrees?

☐

*To be taken at the office by staff with a touchless forehead thermometer.

Does the patient being seen today have a fever or has this person had a fever in the past 14-21 days?	▫ YES ▫ NO	If yes, please explain:
Does the patient being seen today have shortness of breath or other difficulties breathing or have they had these symptoms in the past 14-21 days?	▫ YES ▫ NO	If yes, please explain:
Does the patient being seen today have a cough?	▫ YES ▫ NO	If yes, please explain:
Does the patient being seen today have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	▫ YES ▫ NO	If yes, please explain:
Has the patient being seen today experienced recent loss of taste and/or smell?	▫ YES ▫ NO	If yes, please explain:
Has the patient being seen today been in contact with any confirmed COVID-19 positive patients?	▫ YES ▫ NO	If yes, please explain:
Does the patient being seen today have heart disease, lung disease, kidney disease or any auto-immune disorders?	▫ YES ▫ NO	If yes, please explain:

Positive responses to any of these questions would likely indicate a deeper discussion with the orthodontist before proceeding with elective orthodontic treatment. If you feel that you need testing for COVID-19, please reach out to your general practitioner or the state health department for guidance.

Signature of Responsible Party: _____