Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Park Rapids Family Dental, P.L.L.C.

Dear Patient:

You have come to our office today for a dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Pursuant to statements and orders from the Center for Disease Control (CDC), the American Dental Association (ADA) and Governor Walz, elective, emergency and urgent treatment may be rendered based on the professional judgement of health care professionals. Please be advised of the following:

> While our office complies with MN State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees regarding your lack of exposure.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we will ask a number of "screening" questions both before, during, and after your appointment. For the safety of our staff, other patients, and yourself, it is imperative that you are truthful and candid when answering the questions. Should you answer "yes" to these questions, your appointment may be rescheduled.

Even with our stringent infection prevention protocols in place, most dental treatments generate aerosols which have been identified as a common way in which COVID-19 is spread. Masks will be employed by all clinical employees and by all clinic visitors as we are able; however, it is impossible to perform dental treatment on a patient donning a mask as unrestricted access to the oral cavity is required.

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 dental treatment. I further confirm that I am seeking treatment for a condition that meets the criteria noted above and that I have not recently tested positive for COVID-19 or am I experiencing any symptoms of Covid-19 at this time. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I acknowledge that I could contract the COVID-19 virus outside of this office in circumstances unrelated to my visit here.

I have read and understand the information stated above:

____ ____________________

Patient Signature Date

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Patient Name

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Witness

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