Simsbury Family Dentistry PLLC.

# Patient Request for Treatment, Representations & Consent

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office and the patients, staff and other individuals who come upon the premises.

Accordingly, as a precondition to rendering treatment, I have confirmed that I have no symptoms commonly associated with COVID-19, including fever, shortness of breath, dry cough, runny nose or sore throat and that I have not, within the past 14 days, travelled by airplane, been in close proximity (less than 6 feet proximity) at a gathering of 10 or more persons, or had close contact with a person who has confirmed positive or suspended to be positive for COVID-19.

I consent to the performance of the treatment proposed by my dentist.

**Name:**_____

**Signature:**_____

**Date:**_____