**Angela B. Bateson, DDS**

General Dentistry

1400 S. Main Street, Findlay, Ohio 45850

[www.batesondds.com](http://www.batesondds.com)

BatesonDentistry@gmail.com

419-425-0303

**Consent for Treatment**

Title:

Last Name:

First Name:

Birthdate:

I understand that my dental provider’s goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding treatment during all visits including a time of a pandemic. We remain committed to prevent all infectious diseases per Universal Precautions Guidelines recommended by and exceeding requirements of the ADA, CDC, and Health Department: Wearing masks, taking temperatures, pre-screening questionnaire, limiting visitors, social distancing, chairside pre-rinse to reduce 50% of bacteria/viruses, use of 90% Aerosol reduction devices in the mouth, UV-C lights, HEPPA filters, requiring prepaying for reserved appointments and online forms provide social distancing at the reception area combined are a collective effort to provide a safe office for our guests and staff.

I understand that routine dental procedures may prevent, reduce, and eliminate inflammatory responses that affects other systems of the body causing inflammatory diseases including autoimmune diseases not limited to Alzheimer’s, heart disease, and stroke. It is important to maintain optimum oral health through reduction of inflammation and disease for the whole body health and immunity.

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

I understand a weak or compromised immune system can put me at greater risk for contracting in any environment including dental offices all viruses, including COVID-19. Conditions including, but not limited to, seasonal and systemic allergies, over the age of 65, smoking, alcohol use, pregnancy, autoimmune diseases, diabetes, asthma, COPD, heart disease, history of MI, CVA, TIA, CAD/stents, kidney disease, liver disease, BMI greater than 30, cancer treatment, gastrointestinal disorders, radiation, chemotherapy, and any prior or current disease or medical condition. Please disclose to us any condition that compromise your immune system and understand hat we may ask you to consider rescheduling treatment after discussing any such condition with us.

Viruses can be serious and highly contagious diseases. I understand that I can contract viruses from a variety of sources. I am aware of risks of contracting infectious viruses in all environments including dental offices. I understand that I must disclose to this office any indication of having been exposed to COVID-19 and if I have experienced any signs or symptoms associated with the COVID-19 virus.

**NOTE: BOTH doctor and patient are encouraged to discuss any and all relevant patient health issues including a compromised immune system. I have fully disclosed to my provider any conditions in my health history that may result in a compromised immune system, prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth in this form have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action that take or do not take because of errors or omission that I may have made in the completion of this form. I will report to the doctor Angela Bateson and staff any changes to my health in the 14 days after my visit.**

Patient (Or legal guardian) Signature: Signature Date:

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