**COVID-19 RISK INFORMED CONSENT**

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Marlene Feisthamel and all the staff at Feisthamel Family Dentistry and are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19.

However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this procedure. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this procedure and I give my express permission for Dr. Marlene Feisthamel and all the staff at Feisthamel Family Dentistry to proceed with the same.

I understand that possible exposure to COVID-19 before/during/after my procedure may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my procedure, I may need additional care that may require me to go to an emergency room or a hospital. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

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**INFORMED CONSENT FOR COVID-19 RISK**

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

_____

Patient or Person Authorized to Sign for Patient Date/Time

Witness _____Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____