

Perfect Smile Dental Studio  
24632 State Road 54  
Lutz, FL 33559  
(813)948-6335 Fax: (813)948-6394  
Email: [anamariabushdds@gmail.com](mailto:anamariabushdds@gmail.com)

## COVID-19 Policies & Consent

Dear patient,

As a result of the current COVID-19 outbreak, we have installed new policies for entry into our practice. For your safety and the safety of our other patients and employees, you will:

- Fill out the below consent form prior to your appointment
- Check in for your appointment via text or call and remain in your vehicle
- Require a mask in order to enter the practice
- Once contacted by administration to enter, wash/sanitize your hands upon entry
- Have your temperature taken
- Swish with the provided mouth rinse before treatment

At this time, we ask that patients attend their appointment unaccompanied (unless the appointment is for a minor).

### *Consent*

I, \_\_\_\_\_ (the patient), consent to receive treatment from Perfect Smile Dental Studio during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that under Section 5 of Executive Order 20-112 by Governor DeSantis, elective procedures may resume in dental offices effective Monday, May 4<sup>th</sup>, if the criteria is met for personal protective equipment.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

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I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that neither I nor anyone in my household display or currently has any of the symptoms that are representative of COVID-19, which are outlined above: \_\_\_\_\_ (Initial).

According to the CDC, older adults (65 years and older) and people of any age who experience serious underlying conditions (chronic lung disease, serious heart disease, diabetes, immunocompromised, severe obesity, liver diseases, and chronic kidney disease) might be at higher risk for severe illness from COVID-19.

I confirm that I understand that these risk factors put me and anyone in my household at a higher risk for severe illness from COVID-19: \_\_\_\_\_ (Initial).

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that neither I nor anyone in my household has traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. \_\_\_\_\_ (Initial)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. \_\_\_\_\_ (Initial)

Patient Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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*For Practice Use*

- |   |   |
|---|---|
| <input type="radio"/> Verified patient questionnaire    | <input type="radio"/> Patient given Peroxyl mouth rinse |
| <input type="radio"/> Patient washed hands upon arrival | <input type="radio"/> Patient temperature: _____        |

Employee Name: \_\_\_\_\_ Employee Signature: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_