BEL AIR
DENTAL CARE

Patient Screening and Treatment Consent Form

I _____ attest to the following:

- I am in good health, and have not experienced any symptoms or illness including fever or shortness of breath in the past 14-21 days.
- I have not travelled in the past 14 days to an regions highly affected by COVID-19 (as relevant to your location).
- I have not had contact with any confirmed COVID-19 positive patients.
- I understand that Bel Air Dental Care, LLC is following all universal precautions to help prevent the spread of any communicable diseases, I choose to be treated at Bel Air Dental Care LLC, and I hold the doctors and staff harmless should I subsequently develop an infection.

Signature: _____ Date: _____

Witness: _____ Date: _____

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