Patient Screening and Treatment Consent Form

I _______________________________ attest to the following:

- I am in good health and have not experienced any viral symptoms, including fever or shortness of breath in the last 5 days.
- I have not tested positive for COVID-19 within the last 10 days.
- I have not had contact with any confirmed COVID-19 positive individuals within the last 5 days. Exempt if fully vaccinated/boosted and are asymptomatic.
- 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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