# COVID-19
## TREATMENT CONSENT FORM

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|---|---|
| **Patient Name** | Lilla Horvath |

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. I understand that due to the frequency of visits of other denturist patients, the characteristics of the novel coronavirus, and the characteristics of denture procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a denturist office.

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| **I have a fever greater than 38°C / 100°F** | Yes |
| **I have a new cough** | Yes |
| **I have shortness of breath** | Yes |
| **I have flu-like symptoms** | Yes |
| **I have tested positive for the novel coronavirus** | Yes |

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| **I tested positive on this date**<br>12/17/2020 | **I have since been confirmed negative**<br>Yes |
| **I was confirmed negative on this date**<br>12/16/2020 | **I was confirmed negative by**<br>Thermometer |

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| **I am currently waiting for the results of a laboratory test for the novel coronavirus.** | Yes |
| **I have been outside the country in the past 14 days.** | Yes |
| **I have diabetes** | Yes |
| **I have respiratory problems** | Yes |
| **I have an autoimmune disorder** | Yes |

**I would like to report other conditions**
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✔ I understand it is recommended to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive denture treatment.

✔ I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by any governmental health agency.

✔ I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to denture treatment completed during the COVID-19 pandemic

**Patient Signature**