COVID Consent

We at Dr. Kremer's office want to assure you that we are following the guidelines set forth by the CDC, the ADA, and OSHA to minimize the risk of transmission of COVID-19. Infection control has always been a top priority. Even after following protocols set by the American Dental Association, the Illinois Department of Public Health, and the Illinois State Dental Society it is still possible to contract COVID-19.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray, or aerosol, which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your dental providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the above information and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic at this dental office knowing these increased risks and I fully release Dr. Kremer and staff from any liability related to the COVID-19 virus.

Effective immediately we will be charging a $10 COVID-19 PPE fee at each appointment. If your insurance doesn't cover it or you do not have insurance this fee will be your responsibility.

Printed Name: _____ Date of Birth: _____
(Patient Name)

Signature: _____ Today's Date: _____
(Patient or Parent/Legal guardian)