PEDIATRIC DENTAL GROUP OF HATTIESBURG & LAUREL

Hattiesburg: 601-450-6060 | 6643 Highway 98 Hattiesburg, MS 39402 | Info@PDGHattiesburg.com
Laurel: 601-283-4800 | 1925 Pine Belt Drive Laurel, MS 39440 | Info@PDGLaurel.com

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You and/or your child could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You, your child, 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, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you and/or your child contracting the virus simply by being in a dental office.

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

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

I confirm that I have read the Notice above 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 understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I and/or my child could contract the COVID-19 virus from outside this office and unrelated to our visit here.

I have read and understand the information stated above.

_____ _____

Parent/Guardian Signature Date

_____

Witness

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The Pediatric Dental Group of Hattiesburg and Laurel will file to any dental insurance company, as a **courtesy** only. We do not have access to insurance companies.

In order to file claims accurately, the following information is required from the policy holder.

Please contact the insurance carrier for questions regarding individual policies.

Policy Holder Name: _____

SSN: _____

DOB: _____

Employer: _____

Insurance Company Name: _____

Subscriber ID #: _____

Group Number: _____

Claims Mailing Address: _____

Payor ID #: _____

Thank you for your cooperation.

Pediatric Dental Group

**** Missing insurance information will prompt fee for service****

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COVID-19 PANDEMIC - PATIENT DISCLOSURES

Patient Name: _____

This patient disclosure form seeks information from you regarding you and your child that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

W weal or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you and/or your child at greater risk for contracting COVID-19. Please disclose to us any condition that compromises you and/or your child's treatment after discussing any such conditions with us.

It is important that you disclose to this office any indication of having exposed to COVID-19. or whether you and/or your child have experienced any signs or symptoms associated with the COVID-19 virus.

Do you, your child, or anyone in your household…	**YES**	**NO**
…have a fever or on above normal temperature?	☐	☐
…have a dry cough?	☐	☐
…have a runny nose?	☐	☐
…have a sore throat?	☐	☐
Have you, your child, or anyone in your household…	**YES**	**NO**
…experienced shortness of breath or had trouble breathing?	☐	☐
…recently lost or had a reduction in your sense of smell?	☐	☐
…been in contact with someone who has tested positive for COVID-19?	☐	☐
…tested positive for COVID-19?	☐	☐
…been tested for COVID-19 and are awaiting results?	☐	☐
…traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
…traveled within the United States by air, bus, or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks, and cautions regarding compromised immune system and have disclosed to my child's provider any conditions in mine and/or my child's health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____
Parent/Guardian Signature Date

_____
Witness