DENTAL ASSOCIATES OF WALPOLE

Family ◦ Specialty ◦ Care

TEMP_____
(Parent/Guardian)

TEMP_____
PO2_____

You are receiving dental care during the events of a COVID-19 National Emergency. Please be advised that there may be risks in being in the proximity of dentists, patients, or staff. We are taking precautions to limit the spread of disease, yet there is still a possibility of transmission. Physical distancing from others by the recommended six feet is not possible during dental treatment.

By my signature below I am acknowledging that I understand the risk and am accepting it.

_____
Name of Patient

_____
Patient Date of Birth

_____
Signatur of Patient/Parent/Legal Guardian

_____
Date

_____
Printed Name of Patient/Parent/Legal Guardian