

PATIENT CONSENT FOR CARE

Patient's Name: _____ Date of Birth: _____ ID#: _____

I hereby authorize the Dentists, Hygienists, Dental Assistants and/or other health care providers of the Virginia Dental Association Foundation's (VDAF) Mission of Mercy (MOM) project, some of whom might be closely supervised advanced students, to examine and/or treat me and/or my dependent as named above. I understand that it is my responsibility to notify MOM of any changes in contact information, such as change of address or new telephone number when follow-up may be necessary. I further acknowledge the following:

- I have not been diagnosed with influenza, pneumonia or COVID-19/Coronavirus;
- I am not experiencing any fever, influenza, respiratory illness or similar symptoms;
- the MOM project has the right to withhold treatment and refer me to the local public health clinic if I display symptoms associated with influenza, COVID-19/Coronavirus, or other respiratory illness, including but not limited to fever.
- the MOM project is open to public participants and there is a risk of exposure to influenza, respiratory illness or other communicable diseases or conditions, known or unknown, whether or not readily foreseeable at this time, the MOM project does not have any duty to prevent my exposure to any such illness, disease or condition, and I fully accept and assume all risk and responsibility for any illness, disease or condition to which I may be exposed or that I may incur as a result of my participation in the MOM Project.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

As a health care provider, we are making available to you the following notice:

1. If one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. By checking "YES" below, you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of one of our health care professionals, workers or employees in a way that may transmit the disease, the person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the results of the test.
3. The deemed notice for HIV, Hepatitis B and C exposure has been explained to me and I understand it. ___ Yes ___ No

IMPORTANT NOTICE

DENTAL PATIENT NOTE: While the volunteer hygienists, dentists and oral surgeons offer high quality procedures with good equipment, I understand that because of the number of people needing to be seen, I might not receive multiple extractions or multiple fillings. I understand that I might have certain medical conditions which would keep me from having the type of treatment I am requesting. I also understand that the dental care providers are volunteers, some from out-of-town, and are not available for follow-up care in the event of complications. I agree to seek any follow-up care I might need from my local dentist, health department, family physician or a hospital emergency room.

In consideration of the free health care services received on the date below, I, for myself and anyone entitled to claim through me, do hereby waive and release the Virginia Dental Association, Virginia Dental Association Foundation (VDAF), Mission of Mercy (MOM), and any persons or organizations acting on their behalf or sponsoring or volunteering at this clinic, from all claims of liability arising out of my acceptance of such free care including, but not limited to medical, surgical, dental or other health care or medical advice.

I grant to the VDAF Mission of Mercy and its agents the right to use my picture, voice and other reproductions of my physical likeness in connection with advertising or publicizing VDAF Mission of Mercy and its activities in all form of media in perpetuity.

I the undersigned patient consent to the release of my patient records to other licensed health care professionals as necessary. I have read, or had read to me, and understand and agree to all of the above.

Patient Signature (Parent or Guardian if patient is under 18 years of age) Date: _____