Dr. Heidi's Kid's Dental Center

43731 N. 15th St. West, Suite C, Lancaster, California 93534
(661) 949-0120 Office • (661) 942-2370 Fax
623 W. Avenue Q, Suite B, Palmdale, California 93551
(661) 224-9333 Office • (661) 224-9330 Fax

Pediatric Dentistry
HEIDI HAME, D.D.S., M.S.

COVID-19 Treatment Consent Form

(Patient)

I, ______________________(the parent), consent to have my child receive treatment from Dr Heidi's kids dental center during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.)

I understand that under the CDC and ADA guidelines, do not recommend proceeding with any treatment that is non-essential at this time.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread. _________(Initial)

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that neither my child or myself do not display or currently have any of the symptoms that are representative of COVID-19, which are outlined above: ________ (Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival. ______(Initial).

I confirm that neither myself or my child has not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. ________ (Initial).

I confirm, to the best of my knowledge, that me or my child have not had close contact with an individual diagnosed with COVID-19 in the past 14 days._____ (Initial)

Patient Name:________________________________

Parent/Guardian Signature:____

Date:____________________

For Practice Use:
Doctor Signature:____
Date:_________________

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PATIENT REGISTRATION

Child's Name ______________________ (First / Middle / Last) Cell Phone #1 ______________

Address ______________________ (Street / Apt.) Cell Phone #2 ______________

______________________ (City / State / Zip) Home Phone No. ______________

Child's Date of Birth ______________ Soc. Sec. No. ______________

In case of emergency, please notify ______________________ (Name / Phone) WORK ______________

Person Responsible for Account ______________________ Relation ______________

Address ______________________ (Street / Apt.) Home Phone No. ______________

______________________ (City / State / Zip) Soc. Sec. No. ______________

Employer ______________________ (Name / Street) Driver's Lic. No. ______________

______________________ (City / State / Zip) Date of Birth ______________

Are you presently covered by dental insurance? No____ Yes, one plan only ____ Yes, two plans ____

Name of Insurance Co. ______________________ Group No. ______________

Date Coverage Effective ______________________ Union or Local ______________

Subscriber Name ______________________ Soc. Sec. No. ______________

Name of Insurance Co. ______________________ Group No. ______________

Date Coverage Effective ______________________ Union or Local ______________

Subscriber Name ______________________ Soc. Sec. No. ______________

How did you hear of this office? Yellow pages__________ Saw the building______________

Newspaper__________ Union local______________

Referred by______________________________

PERMIT FOR TREATMENT OF MINOR

I, being the Parent (or Guardian) of the above-named minor patient, do hereby authorize the performance of dental treatment for this patient including what ever procedures the doctor may judge necessary. I do also authorize and request the administration of such anesthetic(s) as may be deemed advisable by the doctor.

SIGNATURE______________________ DATE______________

RELATION______________________ WITNESS______________

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HEALTH HISTORY

Does Patient or Family Member have a Syndrome or Chromosome problem that would prevent them from having Local Anesthetic or Nitrous Oxide? Yes ☐ No ☐

SSN#: ______________

Birthday: ______________

Patient's Name: ______________

I. CHECK APPROPRIATE ANSWERS (Lease blank if you do not understand the question):

Yes	No		
☐	☐	1.	Is your general health good?
☐	☐	2.	Has there been a change in your health within the last year?
☐	☐	3.	Have you been hospitalized or had a serious illness in the last three years? Please explain ______________
☐	☐	4.	Are you being treated by a physician now? Please explain ______________ Date of last medical exam ___/___/___ Date of last Dental appt. ___/___/___
☐	☐	5.	If yes to 4 above, name of Medical Doctor ______________ Phone Number (___) ______________
☐	☐	6.	Have you had problems with prior dental treatment? Please explain ______________
☐	☐	7.	Are you in pain now?

II. HAVE YOU EXPERIENCED:

Yes	No		
☐	☐	8.	Chest pain (angina)?
☐	☐	9.	Swollen ankles?
☐	☐	10.	Shortness of breath?
☐	☐	11.	Recent weight loss, fever, night sweats?
☐	☐	12.	Persistent cough, coughing up blood?
☐	☐	13.	Bleeding problems, bruising easily?
☐	☐	14.	Sinus problems?
☐	☐	15.	Difficulty swallowing?
☐	☐	16.	Diarrhea, constipation, blood in stools?
☐	☐	17.	Frequent vomiting, nausea?
☐	☐	18.	Difficulty urinating, blood in urine?
☐	☐	19.	Dizziness?
☐	☐	20.	Ringing in the ears?
☐	☐	21.	Headaches?
☐	☐	22.	Fainting spells?
☐	☐	23.	Blurred vision?
☐	☐	24.	Seizures?
☐	☐	25.	Excessive thirst?
☐	☐	26.	Frequent urination?
☐	☐	27.	Dry mouth?
☐	☐	28.	Jaundice?
☐	☐	29.	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

Yes	No		
☐	☐	30.	Heart disease?
☐	☐	31.	Heart attach, heart disease?
☐	☐	32.	Heart murmurs?
☐	☐	33.	Rheumatic fever?
☐	☐	34.	Stroke, hardening of arteries?
☐	☐	35.	High blood pressure?
☐	☐	36.	TB, emphysema, other lung diseases?
☐	☐	37.	Hepatitis, other liver disease?
☐	☐	38.	Stomach problems, ulcers?
☐	☐	39.	Allergies to: drugs, food, medications?
☐	☐	40.	Family history or diabetes, heart problems, tumors?
☐	☐	41.	AIDS or ARC?
☐	☐	42.	Tumors, cancer?
☐	☐	43.	Arthritis, rheumatism?
☐	☐	44.	Eye disease?
☐	☐	45.	Skin diseases?
☐	☐	46.	Anemia?
☐	☐	47.	VD (syphilis or gonorrhea)?
☐	☐	48.	Herpes?
☐	☐	49.	Kidney, bladder disease?
☐	☐	50.	Thyroid, adrenal disease?
☐	☐	51.	Diabetes?

Yes	No	
☐	☐	Allergies to penicillin?
☐	☐	Allergies to local anesthetic?
☐	☐	Allergies to latex?
☐	☐	Asthma?

IV. DO YOU HAVE OR HAVE YOU HAD?

Yes	No		
☐	☐	52.	Psychiatric care?
☐	☐	53.	Radiation treatments?
☐	☐	54.	Chemotherapy?
☐	☐	55.	Prosthetic heart valve?
☐	☐	56.	Artificial joint?
☐	☐	57.	Hospitalization?
☐	☐	58.	Blood transfusions?
☐	☐	59.	Surgeries?
☐	☐	60.	Pacemaker?
☐	☐	61.	Contact lenses?

V. ARE YOU TAKING?

Yes	No		
☐	☐	62.	Recreational drugs?
☐	☐	63.	Drug, medicines, (including Aspirin)? Please list ______________
☐	☐	64.	Tobacco in any form?
☐	☐	65.	Alcohol?

VI. WOMEN ONLY

Yes	No		
☐	☐	66.	Are you or could you be pregnant or nursing?
☐	☐	67.	Taking birth control pills?

VII. ALL PATIENTS

Yes	No		
☐	☐	68.	Do you or have you had any other diseases or medical problems NOT listed on this form? Please explain ______________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

PARENT'S SIGNATURE ______________ Dentist's Signature ______________

Date ______________ Date ______________

RECALL REVIEW:

1. PARENT'S SIGNATURE ______________ Date ______________
2. PARENT'S SIGNATURE ______________ Date ______________
3. PARENT'S SIGNATURE ______________ Date ______________