COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) — **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. ________
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. ________
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. ________
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell ________
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days, I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. ________
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. ________
- I have been offered a copy of this consent form. ________

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	____________	Parent / Guardian Signature	____________	Witness Signature	____________
Name	____________	Name	____________	Name:	____________
Date	____________	Date	____________	Date:	____________

Dr. Heidi's Kid's Dental Center

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.

INELIGIBLE STATUS LETTER

DATE:

TO: Dr. Heidi's Kid's Dental Center;

623 W. AVENUE Q, SUITE B, PALMDALE, CA 93551

IF IT SHOULD BE DETERMINED THAT I AM NOT ELGIBLE FOR BENEFITS THROUGH MY INSURANCE COMPANY FOR DENTAL OR ANY RETROACTIVE TERMINATION.
I, ______________________ AGREE TO PAY Dr. HEIDI'S KIDS DENTAL CENTER INC. THE FULL AMOUNT OF THE SERVICES RENDERED TO MY CHILD ON ____________, 20________.

NAME: ____

ADDRESS: ____

____

TELEPHONE NUMBER: ______________________________

SIGNATURE: ______________________________

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HEIDI HAME, D.D.S., M.S.

INFORMED CONSENT

OUR PEDIATRIC DENTAL OFFICE PHILOSOPHY IS BASED ON OUR COMMITMENT TO PREVENTIVE DENTISTRY AND TO CREATE A SUPPORTIVE AND NURTURING ENVIRONMENT FOR THE CHILDREN AND YOUNG ADULTS UNDER DENTAL CARE. IN PARTICULAR, WE ARE DEDICATED TO PROVIDING SAFE, COMFORTABLE AND QUALITY DENTAL TREATMENT FOR ALL OUR PATIENTS.

CALIFORNIA STATE LAW REQUIRES US TO OBTAIN YOUR INFORMED CONSENT BEFORE WE CAN PROVIDE ANY DENTAL SERVICES FOR YOUR CHILD, OUR MOST IMPORTANT GENERAL OFFICE POLICY IS TO "INFORM BEFORE WE PERFORM". SPECIFICALLY, WE ARE REQUESTING YOUR PERMISSION FOR THE FOLLOWING DIAGNOSTIC AND PREVENTIVE DENTAL PROCEDURES: COMPREHENSIVE CLINICAL EXAMINATION, SELECTED DIAGNOSTIC X-RAYS, THOROUGH PROFESSIONAL CLEANING AND DECAY-FIGHTING FLUORIDE TREATMENT.

PLEASE FEEL FREE TO ASK US ANY QUESTIONS YOU MAY HAVE REGARDING THE PRECEDING INFORMATION OR CONCERNING ANY OTHER ASPECTS OF OUR DENTAL PRACTICE. ADDITIONALLY, YOU MAY WISH TO DISCUSS OUR POLICIES WITH OTHER INDIVIDUALS WHO ARE INVOLVED IN CARING FOR YOUR CHILD.

THEREFORE, I HEREBY GIVE MY CONSENT TO DR. HEIDI'S KID'S DENTAL CENTER TO PROVIDE MUTUALLY AGREED UPON DENTAL SERVICES FOR MY CHILD. I AM AWARE THAT DR. HEIDI'S KID'S DENTAL CENTER SPECIALIZES IN PEDIATRIC DENTISTRY. I FURTHER AGREE THAT THIS CONSENT SHALL REMAIN IN FULL FORCE UNLESS WITHDRAWN IN WRITING BY THE PERSON WHO HAS SIGNED BELOW ON BEHALF OF THE MINOR PATIENTS OR THEMSELVES.

______________________	______________________
PRINT PATIENT'S NAME	YOUR SIGNATURE
______________________	______________________
PATIENT'S AGE	PRINT YOUR NAME
	______________________
	DATE

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CONSENT

THE UNDERSIGNED HEREBY AUTHORIZES DOCTOR TO TAKE RADIOGRAPHS, STUDY MODELS, PHOTOGRAPHS, OR OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE DOCTOR TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY THAT MAY BE INDICATED AND FURTHER AUTHORIZE AND CONSENT THAT DOCTOR CHOOSE AND EMPLOY SUCH ASSISTANCE AS DEEMED FIT. I UNDERSTAND THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK.

I UNDERSTAND THAT PAYMENTS FOR DENTAL TREATMENT PROVIDED BY DR. HEIDI'S KID'S DENTAL CENTER FOR MY DEPENDENT(S), IS MY RESPONSIBILITY. I ALSO UNDERSTAND AS A COURTESY, DR. HEIDI'S KID'S DENTAL CENTER WILL BILL MY INSURANCE AT NO ADDITIONAL CHARGE TO ME. HOWEVER, I AM FULLY AWARE THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES OR BALANCES NOT PAID BY MY INSURANCE COMPANY.

I FURTHER UNDERSTAND THAT 1½% FINANCE CHARGE (18% ANNUALLY) MAY BE ADDED TO ANY BALANCE OVER 90 DAYS, TOGETHER WITH SUCH COLLECTION COSTS AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO COLLECT THIS NOTE.

IF YOUR SCHEDULED APPOINTMENT IS NOT CANCELLED WITH A 24 HOURS NOTICE, WE HAVE THE RIGHT TO CHARGE YOU A $50.00 FEE FOR A TREATMENT APPOINTMENT AND A $25.00 FEE FOR A RECALL APPOINTMENT. WE WOULD APPRECIATE IT IF YOU WOULD PAY YOUR PORTION IN CASH, MONEY ORDER OR CASHIER'S CHECK.

______________________________ PARENT'S SIGNATURE

______________________________ DATE

______________________________ CHILD'S NAME

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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#: ______________

Patient's Name: ______________ Birthday: ______________

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

III. DO YOU HAVE OR HAVE YOU HAD:

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

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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______________