**Kanawha County Dental Health Council, Inc.**

**100 Florida Street**

**Charleston, West Virginia 25302**

[**www.kanawhadental4kids.org**](http://www.kanawhadental4kids.org)

Mary C. Snow/ West Side Elementary

**(main clinic-open year round)**

**(304) 348-6613**

**Dental Treatment in the Era of Covid-19**

**Thank you for the continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as the “Coronavirus”, at any time or any place, Be assured that we have always followed state and federal**

**Regulations and recommended universal personal protection and**

**Disinfection protocols to limit transmission of all diseases in our clinics and continue to do so**

.

**Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store or your**

**favorite restaurant. “Social Distancing” nationwide has redued the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our clinics, due to the**

**nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental health providers, staff**

**and sometimes other patients at all times.**

**(FOR OFFICE USE ONLY)**

Date \_\_\_\_\_\_\_\_Approved by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KANAWHA COUNTY DENTAL HEALTH COUNCIL, INC.

**School year 2020-21**

Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Current School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Previous School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current grade \_\_\_\_\_\_\_\_\_ Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last dental visit: \_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_My child will see a private dentist. STOP now and return form to school.**

**\_\_\_\_\_\_\_My child will use school-based dental services. Complete the application.**

**---------------------------------------------------------------------------------------------**

**APPLICATION FOR SCHOOL-BASED DENTAL CARE**

Student date of birth \_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Male  Female

Street address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_

Place of employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Kanawha County Dental Health Council is HIPAA compliant. A Notice of Privacy Practice is available upon request by calling 304-348-6613.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

Please read our Covid statement on the back page of this application and

sign below. Although exposure is unlikely, do you accept the risk and

consent to treatment? YES\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

**Application continued inside →**

Give exact information for **all** children at home:

|  |  |  |
| --- | --- | --- |
| Name | Date of Birth | School & Grade |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

Total number in family\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family household income before taxes (including income from Social

Security, Unemployment, or any other income source).

Father per month $\_\_\_\_\_\_\_\_\_\_\_

Mother per month $ \_\_\_\_\_\_\_\_\_\_

Total $\_\_\_\_\_\_\_\_\_\_\_

CHIP  Medical Card  Private Dental Insurance  None

Patient Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT MEDICAL HISTORY (answer each question)

Yes No Allergy to latex or latex products

Yes No Allergy to antibiotics (penicillin, or\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Yes No Allergy to dental anesthetics (Novocain, etc.)

Yes No Allergy to (food, drugs, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Heart disease, heart murmur, pacemaker, heart defects

Yes No Arthritis, sore joints, artificial joints

Yes No Antibiotic premedication for dental treatment

Yes No Rheumatic fever, scarlet fever

Yes No High blood pressure, frequent headaches

Yes No Fainting spells

Yes No Seizures, epilepsy

Yes No Handicap or disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No AIDS or positive HIV test

Yes No Hepatitis, liver disease

Yes No Diabetes, kidney disease, hypoglycemia

Yes No Blood disorder, anemia, leukemia, hemophilia, sickle cell

Yes No Taking birth control pills

→ → → → →

Yes No Possibility of pregnancy

Yes No Unusual reaction to dental treatment

Yes No Excessive bleeding following injuries or dental treatment

Yes No Mental illness, anxiety, ADD/ADHD

Yes No Respiratory disease (TB, asthma, emphysema)

Yes No Need inhaler or medications during dental treatment

Yes No Currently being treated by a physician for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had a well-child check-up within the last year? Yes\_\_\_No\_\_\_\_\_

**YOUR SIGNATURE BELOW GIVES PERMISSION FOR ANY**

**NECESSARY DENTAL TREATMENT** **AND VERIFIES ALL**

**INFORMATION TO BE CORRECT. YOU MUST BE THE**

**PATIENT’S PARENT OR LEGAL GUARDIAN TO GIVE CONSENT**.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle one: Parent Legal Guardian Patient

Please print your name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check **ONLY** **ONE** of the following:

I will take my child to school-based dental office appointments.

I give permission for my child to be excused from class to receive care

at the dental office if one is located in their school. (**see list on back**)

If there is no dental office in my child’s school, I give permission for my child to ride a school bus to a school-based dental office.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_