



Chart Number _____
(for internal use only)

Lindquist Dental Clinic for Children

Parkland * Bremerton

Patient Screening Checklist & COVID-19 Dental Treatment Consent Form

Child's Name:

Last Name

First Name

Date of Birth

Parent's Name:

Last Name

First Name

Date of Birth

Date of Screening: _____

- | | Child | Parent/
Guardian |
|---|--|--|
| 1. Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you/they in contact with any confirmed COVID-19 positive patients? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Do you/they have a cough? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you/they experienced recent loss of taste or smell? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Do you/they have any unexplained rash? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Do you/they have shortness of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Is your/their age over 60? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have you/they traveled in the past 14 days outside of Pierce or Kitsap County?
If so, where? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Screened by: _____

COVID-19 Pandemic Dental Treatment Consent Form

I (the patient or parent/guardian named above) knowingly and willingly consent for (patient's named above) to have dental care during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Although LDCC is doing their best to abide by the American Dental Association's and the Center for Disease Control's guidelines for best practice, health and safety during COVID-19:

I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I (or my child) may have an elevated risk of contracting the virus simply by being in a dental office.

Phone number while on site: _____

I will not leave the premises while my child is been seen. I will remain either in the waiting room or in my car.

Signature Parent/Legal Guardian _____

Date _____

Signature Doctor _____

Date _____