Sparkles
Dentistry for Children

Name of Patient _____ Date of Birth _____

Preparing for your appointment

Parents please review the guidelines below with your child.

1. Please review, complete and submit this document via email no later than 9AM to info@sparklesdentistry.com.

2. Please brush your teeth just before leaving home and use the bathroom. Our office bathroom will not be accessible to patients at this time.

3. If you have any orthodontic appliances, please make sure to bring them with you to the appointment.

Brush before you arrive!

4. When you arrive to your appointment time, please call 973-744-3127.

5. A staff member will come out to your vehicle, review a few questions and measure the patient's temperature. If temperature is higher than 100 F, the appointment will need to be rescheduled.

6. Every patient must wear their own mask and own sunglasses to enter the building.

7. Once ready for the appointment, only the patient will be accompanied to the appoint-ment room that has been sanitized and prepared. At this time, we will not be inviting parents or caregivers into treatment rooms, unless previously arranged.

8. All children must bring their own sunglasses or protective eye-wear.

KEEP READING!

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At your appointment

We are limiting the number of individuals in the building and enforcing physical distancing.

The HVAC has been replaced and we have installed Jade Surgically Clean Air Units as an additional form of filtration.

The staff will be wearing additional protective equipment such as visors and surgical gowns. This is for patient safety and not in any way meant to intimidate the children.

We will be keeping appointments short. Physical distancing will be enforced to minimize contact.

We continue to clean and sanitize every room thoroughly using universal precautions. We appreciate your compliance and cooperation and we hope you understand that in an effort to comply with State guidelines, we may need to refuse OR reschedule.

Please fill out and return the attached form before 9am on the day of your appointment.

- ☐ **1. I have read and understood the check in protocol.**
- ☐ **2. My child has used the bathroom and brushed his/her teeth just prior to entering the office.**
- ☐ **3. My child has a mask and sunglasses to wear at the appointment.**
- ☐ **4. Child will be accompanied by an adult who will wait outside. Parent (name) _____ can be reached at (phone number) _____ during the course of the appointment.**
- **5. List any new health changes and medications _____**
- **6. Please Pick one Option**
  - ☐ **I will wait in my car.**
  - ☐ **I want to accompany my child to the treatment room.**
  - ☐ **My child will be accompanied by a caregiver and I am available via phone.**
- ☐ **7. I consent to X-rays if needed.**

Parent/Guardian Name _____ Parent/Guardian Signature _____

Name of Patient _____ Date of Birth _____

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?	_____ YES	_____ NO
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO

IF SO, WHERE? _____