Consent for Treatment

We are here to provide dental service to you and your child in the most beneficial way possible. This requires mutual understanding. Please read this form carefully. Should you have any questions, our business coordinators will be delighted to help you. Please read this form carefully & ask abut anything you do not understand. You will be required to e-sign during your visit acknowledging you have read and understand this document.

1. I hereby authorize and direct Super Smiles and/or any of its dental associates and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (X-Rays) and/or any other diagnostic aids in order to complete a through diagnosis and treatment plan.
2. I understand certain parts of the treatment may be performed by certified paraprofessionals (Dental assistants) other than the dentist. (I.E. sealants, radiographs, rubber cup polishing, and sedation monitoring.)
3. I also authorize Super Smiles and/or any of its dental associates and/or dental auxiliaries to take and to use photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific publication. The photographs shall be used for dental records and if in the judgement of Super Smiles and/or any of its dental associates, dental research, education, or science will be benefited by their use, such photographs and information relating to my child's case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which she may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use my name or my child's name not be identified by name. The aforementioned photographs may be modified or retouched in any way that my dentist, in his/her discretion, may consider desirable.
4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request for a fee.
5. In general terms, the dental procedure(s) can include but not be limited to: A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride. B. Application of plastic "sealants" to the grooves of teeth. C. Treatment of diseased or injured teeth with dental restorations (fillings), stainless steel or composite crowns, and/or root canal treatment. D. Oral surgery: Extraction of one or more teeth, excision of hyper plastic and/or pericoronal tissue, frenectomy, exposure of un-erupted tooth. E. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis. F. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection. G. Treatment of habits, malposed (crooked) teeth, orthodontia and/or oral, dental development or growth abnormalities. H. Recommendation for treatment to be completed using conscious sedation or general anesthesia.
6. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.
7. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.
8. I have answered all the questions about my or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should not receive oral medications and/or anti-anxiety agents. I also understand if I or my dependent ever had any changes in health status or any changes in medication (s), I will inform the doctor at the next appointment.
9. I authorize Super Smiles and/or any of its dental associates to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other heath care giver for his/her records, as well as any third parties such as insurance companies who may request information.

PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT
TECHNIQUES ACKNOWLEDGMENT OF RECEIPT OF INFORMATION
ALL IN GOOD INTENTION

It is our intent that all professional care delivered in our dental office shall be of the best possible quality we can provide for each child. We believe that any dentist can get your child's work done- our mission is to do so in a manner which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life. All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In some cases, further behavior management techniques are needed. There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. These techniques are not a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

PEDIATRIC DENTISTRY BEHAVIOR MANAGEMENT TECHNIQUES

The more frequently used pediatric dentistry behavior management techniques are as follows:

1. Tell-Show-Do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. Positive reinforcement: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, pat on the back, a hug, or a prize.
3. Voice control: Is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.
4. Mouth props/Rubber dams: A mouth prop or "tooth pillow" as we call it used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc) This allows him/her to relax and not worry about consciously keeping his/her mouth open for procedure. A rubber dam is a "raincoat" placed on the area of work to be worked on to isolate the teeth and prevent any debris from being swallowed or going to the back of the throat.
5. Immobilization by the dentist: The dentist controls the child from movement by gently holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body.

6. Immobilization by the assistant: The assistant controls the child from movement by gently holding the child's hands, stabilizing the head, and/or controlling leg movements.

7. Immobilization by Pedi-wrap: A passive restraint device, designed specifically for pediatric dental procedures, that is used when complete immobilization is needed for the safety of the patient and the dental team. It is used during most, not all sedation procedures.

8. Relaxation Gas: Nitrous oxide and oxygen (laughing gas) may be administered to relax the child and to raise his/her pain threshold. This allows the child to sit in chair longer / increases their attention span and allows for more work to be done without the child labeling something as painful. Nitrous oxide and oxygen is not general anesthesia. The child is not "put to sleep" and does not become unconscious, only relaxed.

CONSCIOUS SEDATION INFORMED CONSENT FORM

During all dental treatments it may be necessary to use conscious sedation. The purpose of this document is to provide an opportunity for patients to understand and give permission for conscious sedation when provided along with dental treatment.

1. I understand that the purpose of conscious sedation is to more comfortably receive necessary care. Conscious sedation is not required to provide the necessary dental care. I understand that conscious sedation has limitations and risks and absolute success cannot be guaranteed.

2. I understand that conscious sedation is a drug-induced awareness and decreased ability to respond. Patient will be able to respond during the procedure. Patients ability to respond normally returns when the effects of the sedative wears off.

3. I understand that the patients conscious sedation will be achieved by oral, intramuscular or IV route.

4. I understand that the alternatives to conscious sedation are: a. No sedation: The necessary procedure is performed under local anesthetic with the patient fully aware. b. Nitrous oxide sedation: Commonly called laughing gas, nitrous oxide provides relaxation but the patient is still generally aware of surrounding activities. Its effects can be reversed in five minutes with oxygen. c. General Anesthetic: Commonly called deep sedation, a patient under general anesthetic has no awareness and must have their breathing temporarily supported. General anesthesia is more appropriate for longer procedures lasting 3 or more hours.

5. I understand that there are risks or limitations to all procedures. For sedation these include: a. A typical reaction to sedative drugs which may require emergency medical attention and/or hospitalization such as altered mental states, physical reactions, allergic reactions, and other sicknesses. b. Inability to discuss treatment options with the doctor should circumstances require a change in treatment plan.

6. If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

7. I have had the opportunity to discuss conscious sedation and have my questions answered by qualified personnel including the doctor. I also understand that he/she must follow all the recommended treatments and instructions of my doctor.

8. I understand that patient must notify the doctor if patient is pregnant, or if patient is lactating. I must notify the doctor if patient has sensitivity to any medication, of my present mental and physical condition, if he/she has recently consumed alcohol, and if he/she is presently on psychiatric mood altering drugs or other medications.

9. Patient who receive oral sedatives will not be able to drive or operate machinery for 24 hours after his/her procedure. Patient understands that he/she will need to have arrangements for someone to drive he/she to and from his/her dental appointment while taking oral sedatives.

10. I hereby consent to conscious sedation in conjunction with my dental care. I hereby acknowledge that I have read and understood this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent will remain in effect until terminated by me. Please note a signature attesting that you have read and understood the contents of this form will be required during your visit.

Parent/Guardian Signature: