Budding Smiles of Beaver

CONSENT FOR DENTAL PROCEDURE

Patient's Name _____Patient's Date of Birth_____

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. Each recall visit consists of updating insurance information, medical/dental history and reviewing any dental concerns. This is usually followed by a cleaning, oral hygiene instructions, fluoride application and radiographs (x-rays) if needed. The dentist will then complete an exam and review radiographs followed by a discussion of the findings and patient's treatment needs. The radiographs (X-rays) recommended are determined by the dentist based on the standard of care established by the American Dental Association. **No new patients will be examined or treated without radiographs at our office.** Please share your concerns/questions with the staff or the dentist before the appointment. Any further treatment needed after the first or recall appointment such as fillings, caps, extractions, etc., will be performed at a separate appointment after obtaining your permission. We will also be discussing any specialist referrals needed such as Orthodontist, Oral surgeon, Endodontist, etc. and will be happy to provide a written referral if indicated. It is however your responsibility to find the appropriate specialist recommended and make necessary appointments.

State law requires that we obtain your written informed consent for any treatment given to your child as a legal minor.

1. I hereby authorize and direct the doctors/hygienists of BUDDING SMILES OF BEAVER, assisted by dental auxiliaries of his or her choice, to perform upon my child the following dental treatments or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids, and nitrous oxide.
2. In general terms the dental procedures or operation may include:
   A. Cleaning of the teeth and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the permanent teeth.
   C. Treatment of diseased or injured teeth with application of Silver Diamine Fluoride (SDF), dental restorations (fillings or caps/crowns). The caps/ crowns are normally white on the front teeth and silver on the back teeth. Please discuss any concerns/preferences you may have regarding the material being used.
   D. Extraction of severely decayed teeth that are non- restorable.
   E. Placement of space maintainers.
   F. Discussion of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
   G. Use of local anesthesia by injection to numb the teeth worked on. Numbness usually lasts from 1.5 to 3 hours. Allergic reactions are rare, and your child will be cautioned not to bite the numb lip and cheek to avoid self-injury. Please do not tell your child they are going to get a "shot" and allow the dentist to approach this discussion in a more child-friendly manner.
   H. Use of nitrous oxide (laughing gas) will be discussed with you in advance to allow for increased relaxation and improved cooperation during difficult dental procedures. This gas is administered through a mask over your child's nose and is not meant to provide any form of sedation. A separate consent form is reviewed in detail and signed when laughing gas is employed at the office.
   I. You are advised that as with any procedure that utilizes local or general anesthetic, there is a possibility of surgical and or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage, or death.

I further authorize the doctors/ hygienists of Budding Smiles of Beaver to perform treatment as may be advisable to preserve the health and life of my child. I hereby state that I have read and understood this consent and that all questions about the procedures have been answered in a satisfactory manner. I also understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such a time that I choose to terminate it in writing.

_____ _____ _____

Signature of Parent/ Legal Guardian | Relationship to Patient | Today's date