

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.

1. I hereby authorize and direct Just4kids Dental 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 thorough diagnosis and treatment plan.
2. I understand certain parts of the treatment may be performed by certified paraprofessionals (Dental assistants) other than the dentist.
3. I also authorize Just4kids Dental 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 purposes of teaching, research, and scientific publication. The photographs shall be used for dental records and if in the judgment of Just4kids Dental 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 s/he 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 unerupted 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 developmental 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 Just4kids Dental 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 health care giver for his/her records, as well as any third parties such as insurance companies who may request information.
10. The usual and most frequent risks or complications occurring from the planned treatment and procedures include, but are not limited to the following: the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue (e.g. lips, tongue, and cheeks), development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.
11. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's Treatment Plan and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

I hereby acknowledge that I have read and understand 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 shall 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.

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.

Please read this form carefully & ask about anything you do not understand. You will be required to e-sign during your visit acknowledging you have read and understand this document.

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 is 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 the 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.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. I have read and understand the various pediatric dentistry management techniques.
2. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in the pediatric dental community and are merely used only if necessary to provide the best dental care.
3. I have been encouraged to ask questions and all questions about the patient management techniques described have been answered in a satisfactory manner.
4. I hereby acknowledge that I have read and understand this consent.
5. I acknowledge that I have not been coerced/ forced to sign this consent and that I have been given the alternative to withdraw from it.
6. I hereby authorize and direct Just4kids Dental dentists and/or dental auxiliaries of its choice, to utilize, if required, the necessary patient management techniques to assist in the provision of the required dental treatment for my child (or legal ward).
7. I understand that this consent shall remain in effect until terminated by me.

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