Treatment Consent

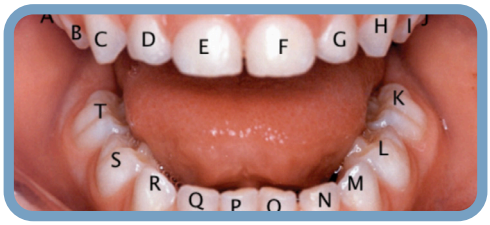
Dr. Camps Pediatric Dental Center

Patient Name

Date

Date of Birth

Treating Doctor



☐ **Fillings** tooth #(s): _____

and any others deemed necessary by the Dentist during the course of treatment. I understand that care must be exercised in chewing with fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after- effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed at additional charge, even though the tooth may not have hurt prior to the filling being placed.

☐ **Pulpal Therapy / Root Canals / Endodontic Treatment** tooth #(s): _____

and any others deemed necessary by the Dentist during the course of treatment. I understand there is no guarantee that Pulpotomy treatment will save my child's tooth, and that complications can occur from the treatment: root canal filling material can extend through the tooth (which will not necessarily affect the success of the treatment) and endodontic files and instruments can separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment and that such additional treatment will be at additional charge to me.

☐ **Crowns** tooth #(s): _____

and any others deemed necessary by the Dentist during the course of treatment. When a tooth is damaged by decay and a filling will not be effective, a crown may be placed. Pediatric crowns can be silver or white in color. Posterior (back teeth) are silver and made of stainless steel. Anterior (front teeth) are white and made of composite filling. I understand that sometimes it is not possible to match the color of artificial teeth to that of my child's natural teeth. I realize the last opportunity to make changes to my child's crown is before permanent cementation. I also understand that after placement of a temporary or permanent restoration, my child's tooth may be temporarily sore or uncomfortable. Occasionally the pulp (nerve tissue) may be irritated by the preparation process or from prior trauma or decay. This may make the tooth extremely sensitive. I understand that, if this persists, root canal or extraction therapy may be necessary at an additional charge.

☐ **Extractions/Removal of Teeth** tooth #(s): _____

and any others deemed necessary by the Dentist in the course of treatment. Risks, benefits and alternatives to treatment have been discussed by the Dentist prior to the procedure. Alternatives, if appropriate, to removal of my child's teeth have been explained to me in detail (Pulpotomy or "baby root canal therapy" and Crowns) and I have elected for extraction. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the following risks associated with having teeth removed: pain, spread of infection, dry socket, swelling, damage to nearby teeth, fractured jaw, loss of feeling in teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time. I understand my child may need further treatment, the cost of which is my responsibility.

☐ **Sealants** tooth #(s): _____

Sealants are a plastic resin that is flowed into and bonded to the natural grooves that occur on the chewing surfaces of the bicuspid and molar permanent teeth. This procedure helps prevent cavities from occurring in the pits and fissures in the chewing surface of the back teeth. Occasionally, the dentist may recommend to "open and seal" the grooves. This occurs when there is already staining or the beginnings of a cavity. The hope is to clean out the groove and place a preventive sealant. However, on occasion, the staining is deeper than expected and may require a filling to properly restore the tooth.

☐ **Nitrous Oxide**

Nitrous oxide/oxygen (laughing gas) is used to breathe during dental treatment to help reduce fear and apprehension. Nitrous oxide/oxygen is a blend of two gases: oxygen and nitrous oxide. When inhaled, it is absorbed by the body and has a calming effect. Normal breathing eliminates nitrous oxide/ oxygen from the body. When breathing nitrous oxide/oxygen, your child will smell a sweet pleasant aroma and experience a sense of well-being. If your child is worried by the sights, sounds, or sensations of dental treatment, he or she may respond more positively with the use of nitrous oxide/oxygen. Nitrous oxide/oxygen is very safe, perhaps the safest sedative in dentistry. It is nonaddictive. It is mild, easily taken, and quickly eliminated by the body. Your child remains fully conscious (keeps all natural reflexes) when breathing nitrous oxide/oxygen. The use of nitrous oxide/oxygen as well as any dental treatment required has been fully explained to me. I have given the Dentist a complete review of my child's medical history. I consent to treatment of my child as explained above and all my questions have been answered.

Local Anesthesia

In connection with my child's dental treatment, local anesthetic may be used. Local anesthesia is commonly used during dental treatment and complications are rare but do at times occur. Risks that can be associated with local anesthesia include dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or additional medical management or hospitalization. In addition, my child may experience restricted mouth opening during recovery, sometimes related to muscle soreness at the site of the injection requiring physical therapy. Local anesthesia may cause prolonged numbness that in some patients may result in injury from biting or chewing an area (lip, cheek or tongue) that has received the local anesthesia. Local anesthesia can cause injury to nerves that can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gum, or tongue which may persist for several weeks, months, or, in rare cases, may be permanent. Local anesthesia is administered with a very fine needle. In rare instances these needles may break off or separate from the hub and become lodged in soft tissue.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/or all changes and additions as necessary.

Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have given the Dentist a complete review of my child's medical history.

The above procedure/s has been fully explained to me. I consent and authorize treatment of my child as explained above. I understand that there has been no guarantee or assurance made by anyone in regard to the dental treatment I have authorized. By signing below, I confirm that I have read the foregoing sections and understand the treatment to be undertaken, as well as the risks, benefits, alternative treatment options and consent to the described treatment. The Dentist has reviewed all the treatment options with me and all my questions have been answered.

Parent/Guardian Name (Print) _____ **Parent/Guardian Signature** _____

Provider Name (Print) _____ **Provider Signature** _____ **Date** _____

Witness Name (Print) _____ **Witness Signature** _____ **Date** _____