Holdbrook
PEDIATRIC DENTAL

CONSENT TO CONSCIOUS SEDATION AND TREATMENT

DATE: _____ TIME: _____

BY MY SIGNATURE I ACKNOWLEDGE THAT MY CHILD WILL NOT BE ABLE TO HAVE ANYTHING TO EAT OR DRINK AFTER MIDNIGHT THE NIGHT PRIOR TO THE PROCEDURE.

I authorize Dr. _____ and his/her Dental Team to perform the following procedures and treatment on my child _____.

- *Dental Restorations*
- *Prophylaxix (teeth cleaning), Fluoride Treatment*
- *Extractions, Space Maintainers*
- *Oral Conscious Sedation with pediatric restraining wrap and mouth prop.*

If any conditions are revealed or arise during the course of the operation, procedure or treatment in addition to or different from those now contemplated, I authorize the performance of such procedure or treatment without termination the initial procedure or treatment to discuss these additional or different procedures or treatment with me.

The nature and purpose of the procedure and treatment, the risks involved and the possible complications, side effects, the risks consequences to no procedure or treatment and possible alternatives to the procedure have been fully explained to me. The material risks, complications and possible alternatives are set forth below and have been discussed with me. I acknowledge and understand the results of the treatment and procedures are not guaranteed and that unpredictable complications might arise in addition to those discussed with me.

ALTERNATIVES TO CONSCIOUS SEDATION ARE:

- *Restraining the patient*
- *Nitrous Oxide/Oxygen relative Analgesia or General Anesthesia in the Operating Room*
- *Electing not to have treatment may result in abscesses, damaging permanent teeth, pain and swelling causing space loss for permanent teeth or serious medical complications including death.*

I authorize Dr. _____ to prescribe and use such sedation agents as they may consider advisable in the procedure. The risks and complications of conscious sedation have been explained to me and the material risks and complications of conscious sedation are listed below. I understand the administration of medications may lead to unpredictable complications in addition to those discussed with me.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include but are not limited to: vomiting, numbness, discolorization, infections, aspiration, allergic reaction, breathing difficulties, or atypical psychological response that may even cause necessary hospitalization, further surgical procedures, disability, and system impairment, nerve damage, brain damage, resulting in falling and subsequent injuries or death.

I consent to medically appropriate disposal of any tissue or teeth which may be removed during the procedure. I consent to the taking and using of any photographs in the course of the procedure for the purpose of advancing medical and dental education, provided that the patient's identity is not revealed by the photographs or any accompanying description. For the purpose of advancing medical and dental education, I also consent to the admittance of authorized observers to the procedure.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE (1) READ AND FULLY UNDERSTAND THE ABOVE CONSENT; (2) THIS FORM HAS BEEN FULLY EXPLAINED TO ME; (3) THAT THE PROPOSED PROCEDURE AND TREATMENT HAVE BEEN SATISFACTORIALY EXPLAINED TO ME IN LANGUAGE THAT I HAVE UNDERSTOOD; (4) THAT THE RISKS, COMPLICATIONS AND ALTERNATIVES TO THE PROCEDURE AND THE TREATMENT HAVE BEEN EXPLAINED TO ME IN A LANGUAGE THAT I HAVE UNDERSTOOD; (5) THAT ALL QUESTIONS HAVE BEEN ANSWERED AND THE EXPLANATIONS REFERRED TO IN THE ABOVE PARAGRAPHS WERE DISCUSSED WITH ME.

*****DUE TO THE NATURE OF THE PROCEDURE PARENTS/GUARDIANS ARE NOT PERMITTED IN THE OPERATORIES DURING ANY SEDATION PROCEDURES. NO EXCEPTIONS WILL BE MADE.*****

_____ _____

Parent's Signature Date

_____ _____

Witness to Obtaining Consent Physician Obtaining Consent

_____

Witness to Parent's Consent Only

DUE TO THE HIGH VOLUME OF SEDATION CASES WE MUST CONFIRM YOUR CHILD'S APPOINTMENT 24 HOURS PRIOR TO THEIR SCHEDULED APPOINTMENT. IF WE CANNOT REACH YOU TO CONFIRM THIS APPOINTMENT IT WILL UNFORTUNATLEY BE CANCELLED. PLEASE MAKE SURE THAT OUR OFFICE HAS CORRECT PHONE NUMBERS TO ENABLE US TO REACH YOU.

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AUTHORIZATION TO CONSENT TO DENTAL TREATMENT OF A MINOR

Patient's Name: _____ Date of Service: _____

I understand that my child will be having the following treatment:

___ Fillings Amalgam (silver)

___ Filling Composite (white)

___ Extractions (Removal of Teeth)

___ Stainless Steel Crowns (Silver)

___ Esthetic Stainless Steel Crowns (White)

___ Pulpotomy (Nerve Treatment)

___ The use of Nitrous Oxide

___ The use of Oral Sedation

___ Sealants

___ General Anesthesia

___ Other

I understand that during the treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth. I give my permission to Dr. _____ to make any/all changes. The authorization is valid until revoked by me in writing.

I have had explained to me, and I have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment, compared with alternative approaches and/or no treatment.

I have had explained to me that my child's dental treatment could result in the following: trauma inside mouth and injection area; excessive numbness; hematoma.

*By signing this consent I understand that due to the nature of my child's appointment if the appointment is confirmed, and my child is a no-show for the scheduled appointment time, that Holdbrook Pediatric Dental may not be able to reschedule the appointment for a future date. Also, all out of pocket expenses need to be paid in full at time services are rendered.

Signature of Parent/Guardian _____ Date _____ Signature of Witness _____

Please Specify relationship to minor:

___ Parent with legal custody

___ Guardian with legal custody

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NITROUS OXIDE INFORMED CONSENT FORM

Patient's Name: _____ Date of Service: _____

The purpose of this Nitrous Oxide infromed Consent is to provide an opportunity for parents to understand and give permission for the use of Nitrous Oxide when provided along with dental treatment. Each item should be checked off after the parent or guardian had the opportunity for discussion and questions.

I accept and understand the Nitrous Oxide is commonly called laughing gas and provides relaxation through inhalation. My child will be aware, fully conscious, aware of his/her surroundings, and able to respond rationally to inquires and directions. The purpose of Nitrous Oxide is to make it more comfortable for my child to receive the necessary dental care with less pain and/or anxiety. I also accept success cannot be guaranteed. I accept and understand that I must follow all recommended instructions.

I accept and understand that the alternatives to Nitrous Oxide are:

- No Nitrous Oxide: *The necessary procedure is performed under local anesthetic only.*
- Oral Conscious Sedation: *Sedation via oral form that will put my child in a minimally depressed level of consciousness.*
- General Anesthetic: *A patient under general anesthetic has no awareness and must have his/her breathing temporarlity supported and is performed in a hospital setting only.*

The use of Nitrous Oxide has been fully explained to me, including the risks involved. I have been fully informed that temporary complications/risks may include, but are not exclusive of: a tingling sensations or a feeling of heaviness, followed by a lighter floating feeling; warm feeling throughout the body, with flush cheeks; laughter or giddiness; detachment from the environment may occur; lightweight or floating sensation; sluggishness and slurring and/or repetition of words; feeling of nausea; vomiting or agitation. All these complications are temporary.

I have had the opportunity to discuss the Nitrous Oxide in conjunction with my child's dental care, and have had an opportunity to ask questions and fully satisfied with the answers I have received.

I have informed the doctor of my child's complete medical history including any recent surgeries or changes in my child's medical history involving lung, respiratory, ear infection, or common cold. I also accept and understand that I must notify the doctor of my child's present mental and physical condition.

I accept and understand that I must notify the doctor if my child is (1) pregnant, (2) has sensitivity to any medication, and/or (3) is presently on psychiatric mood altering drugs and other medications.

Signature of Parent/Guardian Date Signature of Witness

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POST SEDATION INSTRUCTIONS

AFTER THE SEDATION: Your child should be encouraged to drink fluids every 15-30 minutes for the remainder of the day and continue resting. Use of Nitrous Oxide and Oxygen Analgesia by face mask that fits over the nose, mouth opening devices and other dental devices may cause facial drying and irritation. Skin cream or Vaseline™ should be routinely applied to the lips and nose. Since the lips and tounge may continue to be numb your child should not be allowed to chew or bite for at least two (2) hours after the procedure. Doing so can result in injury to the soft tissues of the mouth.

SUPERVISION AFTER SEDATION: Since your child will be drowsy for five to six hours after the appointment. SUPERVISION by an adult must be arranged. If your child wants to sleep, lay them on their side and wake them every fifteeen (15) to thirty (30) minutes to check on him/her.

PAIN OR DISCOMFORT: Your child may experience discomfort after the local anesthesia has worn off. Give your child the weight appropriate dose of children's acetaminophen (Tylenol™) or children's ibuprofen (Motrin™) for the remainder of the day of the next morning. Do not give your child any other medications today without checking with the doctor first.

BLEEDING OR OOZING: A slight oozing of blood from the mouth for a day is considered normal. Call our office if there is excessive bleeding. Sometime a small amount of blood mixed with saliva will appear to be excessive bleeding.

DIET: Maintain a liquid diet, such as clear juices, water, jello, popsicles, etc. for the first hour after returning home. If your child does not vomit, then he/she can have a soft diet for the remainder of the day: soup, pasta, eggs, oatmeal, yogurt, puddings, applesauce, mashed potatoes. Avoid hot and spicy foods.

BRUSHING: Gentle brushing with a soft toothbrush and pea sized amount of toothpaste can begin that evening. It is important that an adult brushes his/her child's teeth and does not just watch the child brush. **Remember** a clean mouth will heal more quickly

CROWNS (caps): If your child has had a crown placed, it is important that no hard or sticky candy may be eaten from this point on, hard and sticky candies will pull crowns off teeth. There may be slight bleeding from around the crowns for a few days. This is normal and it is important to continue brushing these teeth and gums to help them heal faster.

PLEASE CALL OUR OFFICE AT (856)-783-0444 IF YOU HAVE ANY QUESTIONS. IF YOU MUST CALL AFTER REGULAR OFFICE HOURS, DR. HOLDBROOK MAY BE REACHED BY EMERGENCY CELL PHONE AT B56.266.0220

Parent/Guardian Initial's: _____ _____ Date: _____

Holdbrook

CONSENT TO USE PAPOOSE WRAP

Partial or complete immobilization of the patient can be achieved by the use of a device called a "pedi-wrap" with one or more safety belts. These cloth restraints use Velcro™ to secure the patient's head, limbs and abdomen during dental treatment. The patient is under continuous observation during treatment. If the patient is sedated, special attention is paid to maintain a proper airway.

Risks include, but are not limited to: Temporary redness, bruises, and/or rash may result on the part of the body that is secured in the straps, especially if the patient wiggles, perspires or resists the restraint.

Potential Benefit: Reduces or eliminates unmanageable movement; protects the patient and dental team from injury; facilitates the safe delivery of quality dental treatment.

I have read and understand the above information and hereby *give my consent.*

Patient Name: _____

Parent/Legal Guardian: _____

Date: _____ Witness: _____

Holdbrook
PEDIATRIC DENTAL

INFORMED CONSENT

This consent is meant to provide the parent and/or guardian with specific information regarding your child's dental treatment and appointment. By your signature below, you are indicating that our staff sufficiently went over and explained each bulleted item pertaining to your child's dental treatment and appointment:

- Your child's dental treatment may incur an out of pocket expense. Holdbrook Pediatric Dental will work with your insurance company to obtain an estimated out of pocket expense. This fee is never a guarantee of payment from your insurance company. All out of pocket expenses need to be paid in full prior to your child's dental treatment, unless other arrangements have been made at least two (2) days in advance with our front office staff.

- Your child may be receiving fillings during their dental procedure. I acknowledge that I have been advised whether my child is having composite fillings (white) or amalgam fillings (silver). I understand that based on my insurance I may incur a difference in out of pocket expenses.

- Your child may be receiving crowns (caps) during their dental procedure. I acknowledge that I have been advised whether my child is receiving stainless steel crowns for posterior teeth (silver) or prefab esthetic stainless steel crowns for anterior teeth (white). I understand that based on my insurance I may incur a difference in out of pocket expenses.

- For any Operatory appointment including Sedation and General Anesthesia appointments your child's appointment needs to be confirmed at least twenty-four (24) hours in advance. If we cannot reach you to confirm the appointment it unfortunately will be cancelled. Please make sure our office has correct phone numbers to enable us to reach you. By my signature below I understand that if my child's appointment is confirmed, and my child is a no-show for the scheduled appointment time, that Holdbrook Pediatric Dental may not be able to reschedule the appointment for a future date.

- Your child may have eating restrictions associated with their appointment. By signing below I indicate that I have been made aware of such eating restrictions and understand that if they are not followed my child may or may not be able to be seen for their appointment.

- Due to the nature of Sedation procedures, parents/guardians are not permitted to be present during the procedure.

- Due to the nature of the recovery for Sedation procedures, patient's parent/legal guard an is not permitted to bring any other children under the age of ten (10) to the appointment unless accompanied by another adult over the age of eighteen (18).

Parent/Guardian Signature _____ Date _____ Signature of Witness _____

Please specify relationship to child:
Parent with legal custody
Guardian with legal custody

Please sign on the date of service:

Parent/Guardian Signature _____ Date _____