Holdbrook
PEDIATRIC DENTAL
LLC

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)

_____ Fillings 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.

***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 prior to the date of service unless other arrangements are made at least two (2) days prior to the date of serivice.**

_____ _____ _____

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 informed 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 inquiries 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 temporarily 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: 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 am 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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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 (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 appointments 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 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.

- My 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 guardian is not permitted to bring any other children under the age of ten (10) to the appointment unless accompanied by another adult of eighteen (18).

_____ _____

Parent/Guardian Signature Date

_____ _____

Signature of Witness Date

Please specify relationship to child:
___Parent with legal custody
___Guardian with legal custody

Please sign on the date of service:

_____ _____

Parent/Guardian Signature Date