Valley Pediatric Dentistry

PEDIATRIC DENTISTRY CONSENT FOR PROCEDURES

It is the policy of this office to inform parents/guardians of all procedures planned for your child. Each regular examination appointment consists of oral hygiene instruction, cleaning of the teeth, topical fluoride application, x-rays if needed, and examination of the teeth, hard/soft tissues of the mouth, and the bite. *Any other treatment needed such as fillings, caps, extractions, etc, will be performed at a separate visit after obtaining your permission.*

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 of Valley Pediatric Dentistry assisted by dental auxiliaries of his or her choice to perform the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, x-rays, or diagnostic aids (such as intraoral photos).
2. In general terms these procedures may include:
    a. Cleaning of teeth and application of fluoride
    b. Application of dental sealants to the teeth
    c. Treatment of the diseased or injured teeth with dental restorations (fillings or caps)
    d. Nerve treatments, if necessary, including pulpotomies (baby root canals), or pulpectomies (complete baby root canal)
    e. Replacement of missing teeth with dental prosthesis
    f. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts 1.5-3 hours. *Allergic reactions are rare, and your child will be cautioned to not bite the numb lip and cheek. Please do not tell your child they are going to get a "shot", we have child friendly ways to inform then of this that prevents fear.*
    g. Use of nitrous oxide (laughing gas) may be used to help your child relax and feel the injection less. This gas is placed over your child's nose after an explanation is given. This gas is very safe when used in the concentrations administered and the most common side effects include nausea (more likely on a full stomach), and headache (more common with long procedures).
    h. Use of behavior management techniques outlined on Page 2

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 adverse reactions to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage or death. I further authorize the doctors of Valley Pediatric Dentistry to perform treatment to preserve the health and life of my child.

I further understand that parents may be asked to remain in waiting room during procedures to improve the success of the treatment.

I hereby state that I have read and understand this consent and the behavior management techniques on page 2 and all questions about the procedures have been answered in a satisfactory manner. I also understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. This consent remains active until such time that I choose to terminate.

DATE:_____ PATIENT NAME:_____

SIGNATURE OF PARENT OR GUARDIAN:_____

RELATIONSHIP TO PATIENT:_____ WITNESS:_____

Valley Pediatric Dentistry

BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental clinic be the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, due to the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open mouth or keep open for long enough to perform the necessary dental treatment. Also, aggressive or physical resistance such as kicking, screaming, grabbing the dentists hands or sharp instruments can prevent the proper treatment being performed.

All efforts will be used to obtain the cooperation of the adolescent patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of adolescent patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. 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. Then the dentist or assistant shows the child what is to be done by demonstrating on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described.

2. Positive reinforcement: This technique rewards the child who displays any behavior that is desirable. Rewards include compliments, praise, a pat on the back, a hug, or a prize.

3. Voice control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of a command.

4. Mouth props: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.

5. Nitrous Oxide (Laughing Gas): Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or is unable to comprehend or cooperate for dental procedures. This drug is administered as a gas (nitrous oxide and oxygen). The child does not become unconscious.

6. General anesthesia: The dentist performs the dental treatment with the child anesthetized in a hospital operating room. Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for such a procedure. INITIALS:_____DATE:_____

Valley Pediatric Dentistry

FINANCIAL POLICY

INSURANCE BENEFITS: I understand it is my responsibility to inform and update this office of any changes in dental insurance coverage and also update any changes in address or contact phone numbers. I understand that this office requires 24 hours notice in order to verify my child's coverage. If adequate notice is not given, I am aware that it is my responsibility to reschedule my child's dental appointment or pay the full fee of the visit.

UNPAID INSURANCE BENEFITS: All dental services provided, whether the patient has dental insurance or not, are charged directly to the financially responsible party and that he or she is personally responsible for payment of all dental services. If the insurance company has not paid a claim after 60 days of being submitted, this office will require the patient to pay the account balance unless other arrangements have been made. **It is your responsibility to know your plan and its limitations including but not limited to your deductible, plan maximum, and coverage details.**

TREATMENT ESTIMATES: Valley Pediatric Dentistry routinely provides our patients with an estimate of cost for the purposed treatment. Since your insurance determines the benefit payable for services, this office cannot be held responsible for 100% accuracy on what is only an estimate for treatment. This office provides only an estimate based on your insurance coverage. All insurance companies provide a disclaimer when insurance benefits are being quoted: "Information is subject to change. Benefits described are not a guarantee of payment. Actual benefits payments are determined only when a claim is received, eligibility is not a guarantee of coverage."

COLLECTION ACCOUNTS: If an account is turned over to a collection agency and or attorney for collection, the account holder will be responsible for all attorney and collection fees. Any account that is 90 days past due is subject to being sent to collections. Unless other arrangements have been made. I hereby verify with my signature below that I have read and understood the office policies stated above and also grant Valley Pediatric Dentistry and or affiliates permission to contact me in matters related to this form.

PATIENT NAME:_____
SIGNATURE OF PARENT OR GUARDIAN:_____
WITNESS:_____
DATE:_____

Valley Pediatric Dentistry

Date:_____

In my absence, I hereby give authorization for the person(s) listed below to bring my child(ren) to Valley Pediatric Dentistry and to consent for any and all recommended dental/medical services.

Legal guardian must bring child to first dental appointment.

Child(ren) names and date of birth:	Authorized person(s)/Relationship to child(ren)
_____	_____
_____	_____
_____	_____
_____	_____

Parent/Legal Guardian signature:_____
Printed name:_____
This authorization will remain in effect until changes are made by the parent/guardian as signed above.

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Minor Children (ages 15, 16, and 17 only)
My child(ren), _____may be seen for dental attention in the office of Valley Pediatric Dentistry WITHOUT a parent or legal guardian present.
Parent/Legal Guardian:_____

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Adults (ages 18 years or older-ONLY)
I give my consent for the listed person(s) below to have any and all access to my dental records on file with Valley Pediatirc Dentistry.
Adult Signature:_____
Information may be shared with:_____

CONFIDENTIAL MEDICAL HISTORY

Child's physician:_____ Phone #_____
Is your child in good general health? Yes/No.
If no please describe:_____
Where there any problems at birth? Yes/No.
If yes please describe:_____
Are your child's immunization shots all up to date? Yes/No. Any drug or food allergies? Yes/No.
If so please list and describe the type of reaction._____
Has your child had any surgical operations? Yes/No.
If so, please describe:_____
Has your child ever been hospitalized? Yes/No.
If yes, please explain:_____

Please circle yes or no for any of the following conditions you child has had or now has

Allergies	Y / N	Intellectual Disability	Y / N	High fever	Y / N
Autism Specturm	Y / N	Convulsions/seizures	Y / N	Cancer/tumor/cysts	Y / N
PDD-NOS	Y / N	Rheumatic fever	Y / N	Diabetes	Y / N
Eating Disorder	Y / N	Kidney disease	Y / N	High/low Blood pressure	Y / N
Steroid therapy	Y / N	Frequent diarrhea	Y / N	Sinus problems/drainage	Y / N
Asthma	Y / N	Blood disease	Y / N	Ear/eye/nose/throat problem	Y / N
Abnormal bleeding	Y / N	Cleft lip or palate	Y / N	Liver disease	Y / N
Chemotherapy	Y / N	Mumps or measles	Y / N	Tuberculosis	Y / N
Heart trouble	Y / N	Anemia	Y / N	Stomach ulcer	Y / N
Blood transfusion	Y / N	Scarlet fever	Y / N	Jaundice/hepatitis	Y / N
Mental disorder	Y / N	Chicken pox	Y / N	Problems with anesthesia	Y / N
Heart Murmur	Y / N	AIDS virus	Y / N	Thyroid disease	Y / N
Birth defects	Y / N	Down Syndrome	Y / N		

*Any other condition?*_____
CURRENT MEDICATIONS:_____

SOCIAL HISTORY:
Circle if your child has any problems with the following? Speech / hearing / vision / sleep
Do you consider your child to be? Advanced learner / progressing normally / slow learner
Your child's first language?_____
Second language?_____
Is your child adopted? Yes / No. If so at what age?_____
How does your child tolerate medical or dental treatment?_____
Your child's favorite things? (Pet, toy, color, friend, hobby etc.)_____

DENTAL HISTORY:
Why is your child here today?_____
Is this your child's first dental visit? Yes/No. If no, when was the last visit?_____
Does your child receive fluoride in any form? Yes/No. If so, in what form?_____
Have there been any injuries to your child's teeth?_____
How often does your child brush?_____ Floss?_____ At what age did your child stop using a bottle?_____ Sippy Cup?_____

PATIENT NAME:_____
SIGNATURE OF PARENT OR GUARDIAN:_____
WITNESS:_____ DATE:_____