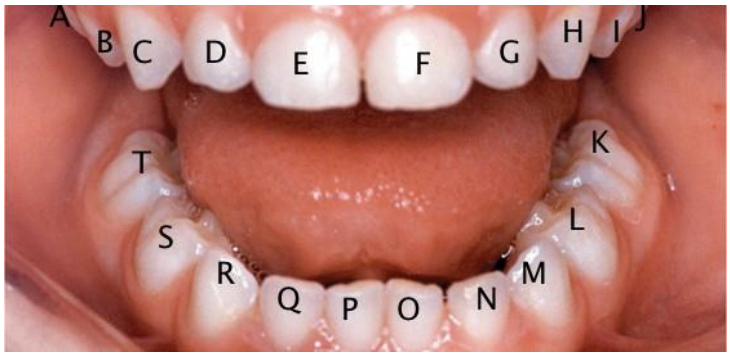
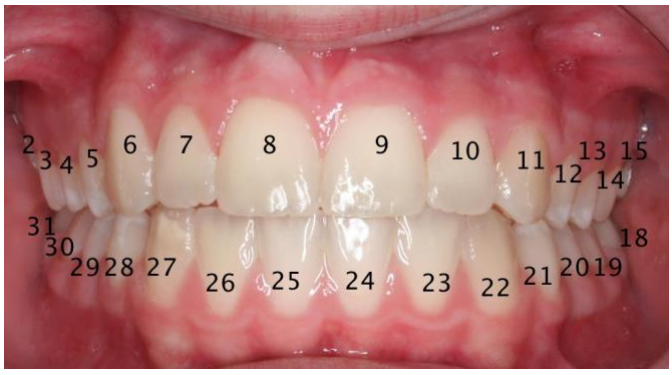
Teeth R US

Children's Dentistry

TREATMENT CONSENT

I understand that by signing below I am requesting and authorizing the procedure(s) to be performed on my child and I have read and understand the possible risks and complications of the procedure(s). The Dentist has reviewed all the treatment options with me and all my questions have been answered.





White Fillings

I authorize Dr. Nathifa Smith, DDS to fill teeth #(s): _____

YES

NO

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.

Pulpotomy/Root Canals/ Endodontic Treatment

I authorize Dr. Nathifa Smith, DDS to treat teeth #(s): _____

YES

NO

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.

REMOVAL OF TEETH (EXTRACTIONS) **I authorize Dr. Nathifa Smith, DDS to extract teeth #(s):** _____

YES

NO

Alternatives to removal have been explained to me (fillings, crowns, root canals) and I authorize the Doctor to remove teeth as indicated in my child's treatment plan. I understand that tooth removal does not always cure infection, if present, and that additional treatment may be necessary. My child may experience pain, swelling, and bleeding as a result of the extraction(s). I will follow the post-operative instructions provided to me and agree to notify the office immediately if my child's condition does not improve as expected

NITROUS OXIDE I authorize Dr. Nathifa Smith, DDS to use Nitrous Oxide

YES

NO

I authorize the Doctor to administer nitrous oxide (laughing gas) to my child during his/her dental treatment. Nitrous oxide is used to help my child relax and to reduce anxiety. It is possible that my child may experience nausea as a result of nitrous oxide.

Space Maintainer I authorize Dr. Nathifa Smith, DDS to do a space maintainer

YES

NO

I have been informed that a space maintainer is needed when a baby tooth is lost prematurely. The space maintainer holds the space open so that the permanent tooth will be able to erupt properly. If a space maintainer is not placed in the mouth, the teeth may shift, causing the permanent teeth to come into the mouth in a less than ideal manner. When this happens, orthodontics (braces) may be required. While a space maintainer will not guarantee straight teeth, I understand that not using one could result in a more difficult orthodontic problem that is more expensive to treat and takes longer to fix.

Pediatric Partial Denture I authorize Dr. Nathifa Smith, to do a pediatric partial denture

I authorize Dr. Nathifa Smith, DDS

I understand that an anterior appliance is used to replace missing front teeth and is important for several reasons. First, the appliance will help my child maintain their smile, ensuring that he/she does not become self-conscious about the way his/her teeth look. Additionally, the appliance helps to prevent developing speech problems. I also understand that the appliance is not necessary to hold space for future permanent front teeth. The teeth in front tend not to shift and rarely create a problem for new permanent teeth. In general, the appliance is not recommended to replace a single missing tooth. I have been informed that the anterior appliance may not be covered by my insurance benefits, and I may be responsible for the charges personally.

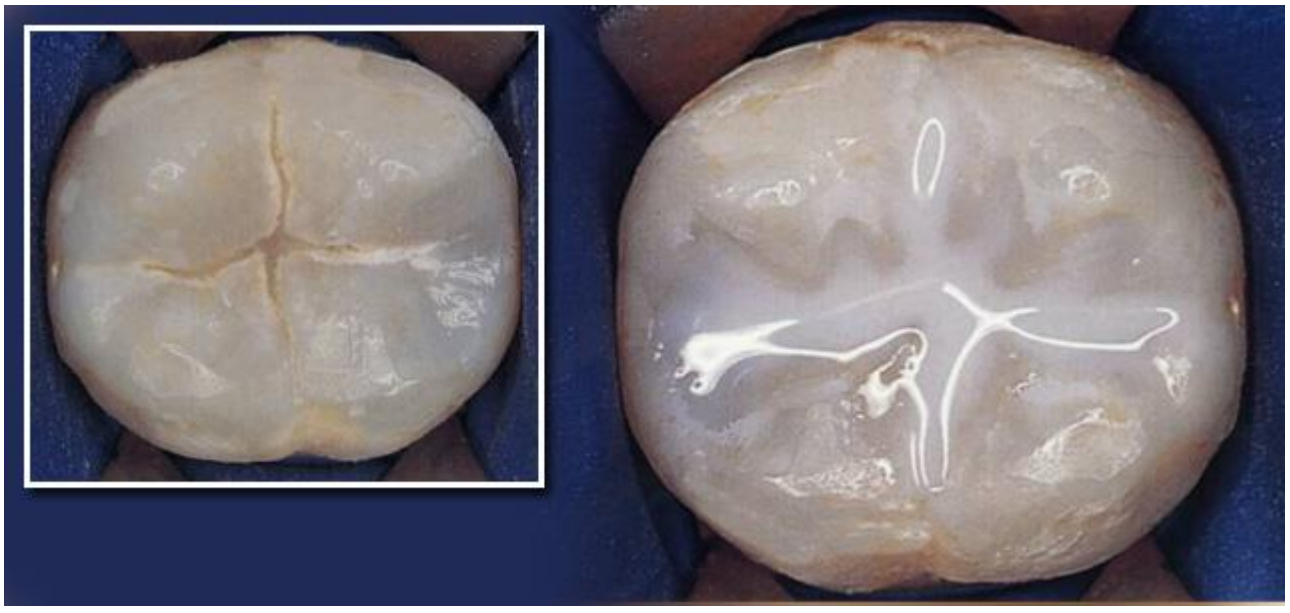
Sealants I authorize Dr. Nathifa Smith, DDS to treat teeth #(s): _____

YES

NO

Sealants are a plastic resin that is flowed into and bonded to the natural grooves that occur on the chewing surfaces of the back primary and permanent teeth. This procedure helps prevent cavities from occurring in the pits and fissures in the chewing surface of the back teeth. I understand that the placement of sealants is intended to prevent dental cavities (tooth decay) in the pits and fissures (grooves) of the chewing surfaces of the teeth. I understand that unsuccessful results and/or failure of dental sealants involve, but are not limited to the following:

1. Loosening, dislodging or leaking: Sealants can become loose or dislodged over a period of time. This time is indeterminable because of many variables including, but not limited to the following: a. The forces of mastication (chewing). These forces differ from patient to patient. b. The types of food or other substances that are eaten or chewed. Very sticky foods such as some types of gum; sticky candies such as caramels; some licorices; very hard substances, etc.; may cause loosening or dislodgment. c. Inadequate oral hygiene such as infrequent or improper brushing of the teeth also may allow leakage around and under the sealant causing it to loosen or allowing a cavity to develop underneath.
2. The entire tooth is not protected with sealants: Sealants are applied to the pits and fissures (grooves) that are on the chewing surfaces of the teeth. Sealants do not protect the areas between the teeth, so thorough brushing and the use of dental floss in these areas is still necessary.
3. Sealant repair: Routine examinations by the Dentist are recommended to allow ongoing assessment of the sealants placed. This will allow the Dentist to repair any sealants as deemed necessary. As a service to our patients, we will repair any of the sealants placed by our office for no additional fee, as long those patients return for their 6-month check-up visits on a consistent basis. I have been given the opportunity to ask questions regarding the nature and purpose of sealants and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with sealant placement in hopes of achieving the desired results from the treatment rendered. By signing this form, I am freely giving my consent to authorize the Dentist and/or all staff members involved in placing sealants, including the administration and/or prescribing of any anesthetic agents and/or medications.



Crowns

YES

NO

I authorize Dr. Nathifa Smith, DDS to treat teeth #(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. Pedo crowns can be silver or white in color. 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.

Local Anesthesia

In connection with my child's dental work, 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 has been fully explained to me. I consent to 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 checked the boxes above and that by checking them I confirm that I have read the foregoing sections and understand the treatment to be undertaken, as well as the risks, benefits, and alternatives and consent to the described treatment. All my questions regarding the above treatment have been answered.

Parent's Name: _____

Relationship to child _____

Signature:

Child's Name: _____

Date: _____