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CHILDREN'S BRACES AND DENTISTRY

A Professional Dental Corporation

PEDIATRIC DENTISTRY INFORMED CONSENT FOR DENTAL PROCEDURES AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Health professionals have an obligation to provide their prospective patients with information regarding the treatment or procedures they are recommending. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain it to you.

1. I hereby authorize and direct Dr. Santiago A. Surillo and Dr. Kenneth Whitcomb assisted by other dentists and/or dental auxiliaries of their choice, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedures.

   - Examination and radiographs (X-rays) as determined by the dentist
   - Cleaning of the teeth and application of topical fluoride
   - Application of plastic "sealants" to the fissures or grooves of the teeth
   - Administration of local anesthetics
   - Treatment of diseased or injured teeth with dental restorations (fillings, crowns and pulpotomies)
   - Removal (extractions) of one or more teeth
   - Treatment of diseased or injured oral tissues (hard and/or soft)
   - Replacement of missing teeth with space maintainers and/or dental prosthesis
   - Use of sedative drugs to control apprehension and/or disruptive or pre-cooperative behavior
   - Use of general anesthesia with an anesthesiologist to accomplish the necessary treatment
   - Postponing or delaying treatment at this time

2. This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages and risks of each. These include pain and/or sensitivity to temperature changes, spontaneous pain, abscess, fracture of the tooth away from the restoration, partial or complete loss of the restoration, amalgam toxicity, failure and/or loss of the porcelain and/or composite restoration, loosening of the crowns necessitating their replacement or re-cementation. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee either expressed or implied, as to the result of the treatment or as to the cure.

3. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well being in the professional judgements of Drs. Surillo and Whitcomb and/or any of his associates of their choice.

4. I understand and have been informed that there are possible risks and complications associated with administration of local anesthesia, sedation, and drugs. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling and/or prolonged numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare and potential risks such as unfavorable reactions to medications, like respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

5. I have also been made aware that after the 1st appointment I will not be able to stay with my child during his/her dental treatment appointment. My presence at subsequent follow-up examinations will be subject to my child's age, maturity, behavior and cooperation.

I hereby state and acknowledge that I have read and understand this consent, and that all questions about the procedures and treatment plan have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment.

_____ _____

PATIENT'S NAME SIGNATURE OF PARENT OR LEGAL GUARDIAN

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RELATIONSHIP TO PATIENT WITNESS

PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Health professionals have an obligation to provide their prospective patients with information regarding the treatment or procedures they are recommending. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain it to you.

It is our intent that all professional care delivered in our dental operatories shall be of 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, because of 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 the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments. Some of these behaviors will be age-appropriate for the child and some may not.

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

There are many behavior management techniques used by pediatric dentists and approved by the American Academy of Pediatric Dentists to gain the cooperation of child patients to eliminate or reduce disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The pediatric dentist may utilize extended appointment time frames in order to have a significantly greater amount of time and extra staff necessary to be successful in handling challenging situations. The most frequently used pediatric dentistry behavior management techniques used in this office can be summarized as follows:

1. TELL-SHOW-DO: The dentist or assistant explains to the child what is to be done using simple age-appropriate terminology. Secondly, the child is shown the procedure on a model, the finger of the dentist or assistant. Lastly, the procedure is performed for the child as described.
2. POSITIVE REINFORCEMENT: Praise is given to the child in order to reinforce cooperative behavior. Desirable behavior is rewarded with an acknowledgement that the behavior is good.
3. VOICE CONTROL: The attention of a disruptive or uncooperative child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is many times less important than the abrupt, sudden or strict nature of the command.
4. SOLO COMMUNICATION WITH CHILD: The pediatric dentist asks that the parent be an observer at chair-side and let the dentist verbalize with the child one-on-one.
5. MOUTH PROPS: A rubber or similar type device is placed in the child's mouth to prevent closing and possible injury when a child refuses or has difficulty maintaining an open mouth.
6. PHYSICAL RESTRAINT BY THE DENTIST OR DENTAL ASSISTANT: The dentist or assistant (under direction by the dentist) restrains the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movements.
7. PHYSICAL RESTRAINT BY THE PARENT: The parent may be asked to help with controlling undesirable movements or just to provide security by holding the child's arms in his/her lap.
8. PAPOOSE BOARD AND PEDI-WRAP: These are restraining devices for limiting the disruptive movements of a child in order to prevent injury and to enable the dentist to provide the indicated treatment. The child is wrapped in one of these devices, which is placed on a reclined dental chair.
9. HAND-OVER-MOUTH EXERCISE: The disruptive, screaming or hysterical child has a hand placed over his/her mouth. When the hand is in place, the dentist softly speaks into the child's ear to stop the screaming and the hand will be removed. The child can then hear the directions from the dentist or assistant.
10. SEDATION: Various drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for dental procedures due to his/her age or mental maturity. These drugs are administered orally along with Nitrous Oxide-Oxygen gas. The child does not become unconscious, but your child may fall asleep. Your child will not be sedated without you being further informed and obtaining your specific consent for such procedure.
11. GENERAL ANESTHESIA: The dentist performs the dental treatment with the child anesthetized by a certified anesthesiologist, usually in a hospital or outpatient operating room. Further informed consent will be explained to you by us and by the hospital team at Children's Hospital-San Diego.

The listed pediatric dentistry behavior management techniques have been explained to me. Alternative techniques, if any, have also been explained to me, as have the advantages and disadvantages of each. I hereby authorize and direct Drs. Surillo and Whitcomb assisted by dentists and dental auxiliaries of their choice, to utilize the behavior management techniques listed on this consent form to assist in the provision of the necessary dental treatment for my child (or legal ward). I hereby acknowledge that I have read and understand this consent, and that all questions about behavior management techniques described have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my child's treatment. I further understand that this consent shall remain in effect until terminated by me.

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PATIENT'S NAME SIGNATURE OF PARENT OR LEGAL GUARDIAN