Santa Teresa DENTAL
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PARENTAL DISCUSSION AND INFORM CONSENT FOR YOUR CHILD'S DENTAL TREATMENT
Rev 03/2018

Your child is in need of dental care. This form explains the care that your child needs, and requests your permission to provide that care.

DENTAL FILLINGS:
Decay dissolves the tooth, and if not treated, will result in an abscessed tooth causing pain and infection. The dentist will remove the decayed and weakened part of the tooth and replace it with a silver alloy or tooth colored material to strengthen the tooth. A local anesthetic may be used that will "numb" the area being treated for one or two hours. If the decay area is too large, it may require a stainless steel crown. I understand the placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time.

STAINLESS STEEL CROWNS:
If a tooth is badly destroyed by decay, a filling will not stay in place. Therefore, a tooth is trimmed around the sides and a preformed crown or "cap" is placed over the tooth to protect it from breaking. As with fillings, the area is usually treated with an anesthetic to help the child remain comfortable for one to two hours. Stainless steel crowns are generally silver in color. Esthetic stainless steel crowns are available. They are semi-custom made; therefore, they need to be ordered and received prior to the appointment. The tooth and gum tissue may be sore after stainless steel crown placement. You may give the child Tylenol and supervise warm salt water rinses as needed. Please stay away from sticky candies as this may pull off the crown.

NERVE OR PULP TREATMENT:
When the decay or infection progresses far enough that the tissue inside the tooth is infected, all or part of that infected tissue must be removed and a special filling placed in order to keep the infection from spreading to other parts of the body. The treatment can take up to two visits during which an anesthetic will be used. Pain or swelling after this work is possible and usually minor. Antibiotics may be used to control possible infections. After treatment, a filling or stainless steel crown will be placed to help strengthen the tooth and keep it from breaking.

SEALANTS:
Back teeth have grooves and pits in which decay usually starts. The dentist or hygienist will "seal" the grooves with a plastic coating to help prevent the decay from starting. No anesthetic is needed.

EXTRACTION OR REMOVAL OF THE TOOTH:
If the infection has spread too far to rebuild the tooth, it is often best to remove the tooth to prevent infection

from spreading. After "numbing" the area with anesthetics, the tooth is removed and the area packed with gauze to control bleeding. Care should be taken not to rinse for a couple of days or bleeding may begin again. Biting on gauze or towels will usually stop the bleeding. Pain or swelling after this work is possible and usually minor.

SPACE MAINTAINER:
It is recommended when baby tooth or teeth are lost prematurely. It helps maintain the natural space intended for a permanent tooth by preventing adjacent teeth from shifting together and forcing permanent teeth to erupt in a crowded condition. Space maintainer can be fixed or removable. Most time we elect fixed appliance due to lack of patient compliance for removable devices. It is fixed in your child's mouth by bands and space(s) are kept open with wire. Diligent care must be used to keep it clean. If not, decay may form and will lead to additional dental treatment. Soreness of the area shortly after it is placed may occur. The space maintainer may interfere with soft tissue such as tongue, cheek and gums. The maintainer may come loose and require reseating assuming it will fit again. If not, a new one may need to be made at the regular fee.

NITROUS OXIDE AND/OR PREMEDICATION:
If a child is particularly nervous about dental treatment, the dentist may use "laughing gas" (nitrous oxide) or some other medication to help relax the child so the work can be done properly. The medications may cause the child to be drowsy after the appointment.

TREATMENT PLAN CHANGE AND/OR ADDITION:
During the incidences when a general anesthesiologist was utilized, parents authorize the dental practice and the dentists to use their professional judgment in making decisions regarding your child's treatment as the circumstances warrant in fulfilling the health-related, function and aesthetic objectives set out in your child's treatment plan and clinical records.

I understand that unforeseen circumstances may arise that may necessitate a decision being made on my child's behalf. I give the dental practice and the dentist's full authorization to make treatment plan changes and/or addition.

IN CASES THE CHILD BECOMES UNCOOPERATIVE:
I understand that should the patient become uncooperative during dental procedures with movement of head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stability the head and/or control leg movements. I may also change the tone or volume of my voice in order to gain the attention of a disruptive or uncooperative child; this technique is call voice control. Procedure may not be continued or completed if safety and cooperative cannot be maintained. Your child may need to be referred to a specialist which is your

responsibility.

RISKS

***For Local Anesthesia* used**

I understand that the child may receive a topical and/or local anesthetic by injection and/or other medication(s). I understand that he/she may have loss of feeling in his/her teeth, lips, tongue and surrounding tissue (paresthesia) following injections. In rare instances, patients can have a strong and unpredictable reaction to the anesthetic, which may require emergency medical attention. The medication may affect the ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. *Depending on the anesthesia and medications administered, the child may need a designated driver to take him/her home. Rarely, temporary or permanent nerve injury resulting in loss of feeling of the chin, lips, gums, tongue and partial loss of taste can result from an injection.*

For Medication(s) used in this office

I understand that all medications in this office have the potential for accompanying risks, side effects and drug interactions. They can cause redness and swelling of the tissues, pain, itching, vomiting and/or anaphylactic shock. I attest that to my knowledge, I have given an accurate report of the child's physical and mental health history. I have also report any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to the child's health.

For Holding Mouth Open During Treatment

I understand that holding the mouth open during treatment may temporarily leave the child's jaw feeling stiff and sore and may make it difficult for him/her to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a most significant condition or problem. In the event this occurs, I must notify this office if the child experiences persistent trismus or other similar concerns arise.

FOR ALL PATIENTS

I understand that every reasonable effort will be made to ensure the success of the treatment. I further understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The dentist will explain all changes.

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I have been given the opportunity to ask questions about Your Child's Dental Treatment and believe that I have sufficient information to give my consent as noted below.

CONSENT

I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed treatment. I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition. I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered. I authorize and direct the dentist to do whatever he/she deems necessary and advisable under the circumstances. I consent to have treatment performed. While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

If I am signing for a minor child, I attest that I am the parent and/or a legal guardian or I have the permission of the child's parent and/or a legal guardian (a separate authorization form is required). If I am signing for an adult, I attest that I am a legal guardian and am authorized to make medical and financial decision on patient's behalf.

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