

Dr. Tiffany A. Brady

Pediatric Dentist

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**NEW PATIENT REGISTRATION FORM**

**Patient (Child’s) Information**

Patient (Child’s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: □Male □Female Age \_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party (Parent/Legal Guardian) Information**

|  |  |
| --- | --- |
| Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_/\_\_­\_/\_\_\_\_\_Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_Phone: Home: \_\_\_\_-\_\_\_\_-\_\_\_\_ Work:\_\_\_\_-\_\_\_\_-\_\_\_\_\_ Cell: \_\_\_-\_\_\_\_-\_\_\_\_\_\_Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_ | Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_/\_\_­\_/\_\_\_\_\_Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip: \_\_\_\_\_\_\_\_Phone: Home: \_\_\_\_-\_\_\_\_-\_\_\_\_ Work:\_\_\_\_-\_\_\_\_-\_\_\_\_\_ Cell: \_\_\_-\_\_\_\_-\_\_\_\_\_\_Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_ |

**If anyone other than above will bring the child to their dental appointment, please include their name below. Please note – child will NOT be seen if name is not included here unless a notarized form is provided from parent/Legal guardian.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Relationship

**Emergency Contact:** Name someone, besides yourself, that we may contact in the event of an emergency

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Name of Child’s Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_ Is Patient in Good Health? □ Yes □ No Weight: \_\_\_\_\_ lb

**Any history of major illness?** □Yes □No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ever been hospitalized or had surgeries?** □Yes □No If yes, Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a history of any of the following? (Please check all that apply): □**None of the Below Apply**

|  |
| --- |
| □ Heart Murmur/Disease□ Cancer□ Sickle Cell Disease□ Organ/Bone Marrow□ Transplant□ HIV/AIDS□ Bleeding Disorder□ Rheumatic Fever□ Communicable Disease (Tuberculosis, whooping cough, rotavirus, etc) |

□ ADHD

□ Cystic Fibrosis

□ Fainting/Dizziness

□ Nutritional Disorder

□ Asthma

□ Diabetes

□ Hearing Disorders

□ Prolonged Bleeding

□ Autism

□ Developmental Delay

□ Downs Syndrome

□ Hepatitis

□ Bone Disorders

□ Ear Infections

□ Speech disorder

□ Epilepsy/Seizure

□ Liver/Kidney Disorder

□ Tonsillitis

□ Cerebral Palsy

□ Endocrine Disorder

□ Mental Disorder

□ Other: \_\_\_\_\_\_\_\_\_\_\_

Please elaborate on checked items: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child require Antibiotic Prophylaxis prior to dental treatment?** □Yes □No

**Does your child have any Allergies?** □ **No Known Allergies**

 □Latex □Penicillin □Medications □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child take any medications?** □Yes □No

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

**Is this your child’s first visit to a dentist?** □**Yes** □**No If no, date of last dental visit:\_\_\_\_\_\_\_\_\_**

**How many times per day does your child brush?** □**0** □**1** □**2** □**3 Adult Supervision?** □**Yes** □**No**

**Is your child using Fluoride toothpaste?** □**Yes** □**No**

**How many times a day does your child floss?** □**0** □**1** □**2 Adult Supervision?** □**Yes** □**No**

**Has your child ever had any trauma or injuries to the mouth, head or teeth?** □**No** □**Yes \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child currently have any dental pain?** □**No** □**Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has your child had dental pain/infection in the past?** □**No** □**Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child have any of the following habits? □ None of the below apply**

 □ **Thumb/Finger Sucking** □ **Nail Biting** □ **Bruxism (teeth grinding)** □ **Pacifier use** □ Snoring

**Dental Insurance Information**

|  |  |
| --- | --- |
| **Primary Insurance**:Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_Insured Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Co. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Secondary Insurance:**Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_Insured Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

I certify that I have read and understand the above. I acknowledge that the questions above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Media Consent**

The undersigned hereby grant LUV Pediatric Dentistry and its employees the right to use photographs, videos, or interviews of my child for office purposes and social media. The undersigned also hereby releases LUV Pediatric Dentistry and its employees, from any and all claims, demands, causes of action and suits arising out of or in connection with the use of these photographs, videos, or interviews.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attendance Policy**

* In order to ensure all of our patients receive timely and quality care, we enforce a strict lateness policy. In the event that you are running late for your appointment, please contact the office so we can better assist you.
* Late arrivals may result in longer wait times necessary to accommodate you into the schedule.
* We reserve the right to reschedule your appointment if necessary.
* Please allow at least 24 hours to cancel of reschedule your appointment. We enforce a strict cancellation/failed appointment policy.
* Excessive lateness/cancellations without notice may result in dismissal from the practice.
* LUV Pediatric Dentistry prides itself on provided exceptional care to all its patients. While we always strive to see all patients at their appointment time, we take the time to treat children who are apprehensive or have special needs, in some cases this may cause delays in your child’s care. We appreciate your patience in ensuring that every child’s needs are met.
* Our waiting area has limited seating; we kindly ask that you limit the amount of family members accompanying the patient whenever possible.
* Any patient with an after-hour emergency may go to the nearest emergency room for immediate attention.

I certify that I have read and understand the above. I acknowledge that the questions above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations.Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS**

 If you want more information about our privacy practices or have questions or concerns, please contact us.

 If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

200 Independence Avenue, S.W. - Washington, D.C. 2020

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL CONSENT FOR PEDIATRIC DENTAL TREATMENT**

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

# CONSENT FOR GENERAL PROCEDURES

### Dental Prophylaxis (Cleaning) and Topical Fluoride Treatment:

A licensed health care professional will be cleaning and applying fluoride to your child’s teeth as a means of preventing tooth decay (dental cavities). Fluoride is applied topically to teeth in the form of a gel or varnish after the cleaning is complete. The fluoride helps strengthen the teeth and prevent tooth decay.

### Dental Radiographs:

The use of radiographs, or x-rays, allows the doctor to detect dental problems before serious damage is done to your child’s teeth, gums and supporting bones and structures. If these conditions are not detected until they are visible or painful signs of disease, your child’s oral health can be seriously affected. Dental radiographs are a part of a comprehensive oral examination. The doctor may not be able to complete a comprehensive exam or properly diagnose your child’s oral health condition without the use of radiographic images.

### Dental Restorations (Fillings):

Dental caries (decay) is the most common disease of childhood. The bacteria that cause decay dissolves the tooth, and if left untreated, will result in an abscess, causing pain and infection. In severe cases, these infections can be life-threatening to children. The dentist will remove the decayed and weakened portion of the tooth and replace it with a resin-based material to strengthen the tooth. A local anesthetic may be used to “numb” the area being treated. The effects of the local anesthetic may last for one to two hours following the procedure.

### Sealants:

Molars (back teeth) have grooves and pits where decay usually starts. The dentist or health care professional will help to prevent decay from starting by using a plastic coating resin-based material to “seal” these grooves. Local anesthetic is not needed.

# PROCEDURES FOR WHICH CONSENT IS REQUESTED

### Stainless Steel Crowns:

In cases of severe tooth destruction, a simple filling will not stay in place and a stainless-steel crown (“cap”) will need to be placed. Your child’s tooth will be trimmed around the sides and a preformed crown is placed over the tooth to prevent it from breaking. As with fillings, the area is usually treated with a local anesthetic to help the child remain comfortable throughout the procedure and may last for one to two hours after.

### Pulpotomy (Nerve/Pulp Treatment):

When decay progresses far enough that the tissue within the tooth is infected, a portion or all the infected tissue must be removed. A special filling will be placed to prevent the infection from spreading to other parts of the body. The treatment will require the use of a local anesthetic, and may require at least two visits to complete. Pain or swelling is rare and usually minor following this procedure. Antibiotics may be used to control possible infections, but are not always necessary. After treatment, a filling or crown will be placed to help strengthen the tooth and keep it from breaking or getting re-infected.

### Extraction or Removal of a Tooth:

If your child’s infection has spread to far, it is often best to remove the tooth to prevent infection from spreading and further jeopardizing your child’s health. After application of local anesthetic (“numbing” the area), the tooth is removed and the area will be packed with gauze to control bleeding. Biting on gauze or towels will usually stop the bleeding, however, care should be taken not to rinse for a couple of days or bleeding may begin again. Usually no antibiotic is required after removal of a primary tooth. Pain or swelling in the area is rare and usually minor.

### Behavior Management Techniques:

In order to successfully complete your child’s dental treatment, the dentist and staff may need to use techniques to help your child cooperate. These techniques include: Voice Control, Distraction, Tell-Show-Do, Positive Reinforcement, and Parental presence/absence from the treatment room. The use of a “mouth prop” may also be needed to maintain your child’s mouth open during the exam or treatment. In certain cases, the use of physical restraint (papoose board) may be needed to immobilize and maintain the safety of your child during treatment.

### Nitrous Oxide:

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 and safely.

POSSIBLE RISKS ASSOCIATED WITH DENTAL PROCEDURES

Although good results are expected, some risks are known to be associated with dental procedures. These risks include but are not limited to: pain, bleeding and swelling, tooth discoloration, nausea, vomiting, hyperventilation, fainting, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. The listed pediatric dentistry behavior management techniques have been explained to me. I understand their use, and the risks/benefits/alternatives available. I have had all my questions answered and I realize I can always seek further information or revoke permission for any of these techniques.

1. I understand that my child may need to receive one or more of the dental services listed and explained about from LUV Pediatric Dentistry.
2. I understand that none of the additional consent procedures will be performed without discussing the necessity with me and obtaining my consent to proceed. I am advised that good results are expected; however, the possibility of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implies, can be given to me regarding treatment.
3. I fully understand and authorize the doctor to perform any necessary treatment that in his/her judgment will be in the best interest of my child’s health, once treatment has begun. Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgical procedures, medication, and/or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, and scarring. I understand and accept that complications may require medical assistance and hospitalization.
4. I understand that during treatment it may be necessary to change or add procedure because of conditions found while working on the gums or teeth that were not discovered during examination. The most common being the need for pulp (nerve) therapy or extraction following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.
5. I understand that PHOTOGRAPHS AND LIVE VIDEO RECORDING are used to document and assist with my child’s care. These images may be used for insurance claim submittal. These images and videos may also be used for educational purposes in study club meetings, lectures, seminars, demonstrations and professional publications (journals, magazines, etc). If these photographs or any digital recordings are used in any publication or as a part of a demonstration, my child’s name or other identifying information will be kept confidential.

# PARENTS/LEGAL GUARDIAN PRESENCE FOR TREATMENT

* Parents or legal guardian must be present for each visit and must remain in the office for the duration of the visit.
* Legal guardians must bring court appointed paperwork to verify guardianship.
* You do have the option of sending your child with another adult over 18 years old, however, you must submit a Treatment Decision Assignment form before your child will be seen.

# BEHAVIOR MANAGEMENT CONSENT

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 dentist’s hands or sharp instruments can result in physical injury and prevent the proper treatment being performed on your child.

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. Praise is used to reinforce cooperative behavior
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. Sedations: 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. These drugs may be administered orally, by injection or as a gas (nitrous oxide and oxygen). The child does not become unconscious. You child will not be sedated without you being further informed and obtaining your specific consent for such a procedure.
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.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_