The Center for PEDIATRIC Dental Care & Orthodontics

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Please read the following information carefully and sign where indicated.
Your signature confirms your understanding and acceptance of this information.

Our office philosophy is based on our commitment to preventive dentistry and to creating a supportive and nurturing environment for the children and young adults under our dental care. In particular, we are dedicated to providing safe, comfortable, and quality dental treatment for all of our patients. Our most important general office policy is to "inform before we perform."

This information is provided to help you understand the limitations of and information about dental treatment as a patient at The Center for Pediatric Dental Care LLC. We want to be certain that you are well-informed regarding **treatment procedures**, **expected benefits and risks, alternatives, consequences of no treatment, and costs of treatment** so that you are well informed and confident that you wish to proceed.

Comprehensive Care
The philosophy at The Center for Pediatric Dental Care LLC is to provide its patients with patient-centered comprehensive care that addresses their dental needs. I hereby authorize the doctors at The Center for Pediatric Dental LLC and their staff to perform a clinical examination, take selected diagnostic x-rays, perform a thorough professional cleaning and fluoride treatment. Failure to follow through with recommended treatment increases the risk of dental caries, gingival irritation, halitosis, and stained teeth. I grant permission for any other necessary diagnostic aids (e.g. impressions, study models, photographs) deemed appropriate to make a thorough diagnosis of my child's dental needs. This includes sharing of information with dental and medical specialists, including, but not limited to orthodontists, endodontists, oral surgeons, periodontists, general dentists and primary care doctors.

Restorative (Composite "White" Fillings, Stainless Steel Crowns, Pulp "Nerve" Therapy) Treatment
Part of our goal in providing comprehensive care at The Center for Pediatric Dental Care LLC is the elimination of tooth decay and the restoration of function using materials that are well suited to the condition of the teeth. For larger areas of dental decay, nerve treatment may be needed. Nerve treatment is not always successful; however, the goal is to save the tooth for as long as possible. Failure of nerve treatment may result in infection, pain and extraction of the tooth. The standard of care is that following a nerve treatment, the tooth needs to be restored with a crown. A comfortable bite block ("tooth pillow") may be used to assist in visualization of the teeth. If necessary, the assistant gently protects the child from movement by holding the child's hands, stabilizing the child's head or positioning the child safely in the dental chair.

Benefits of Restorative Treatment:
- Removal and replacement of diseased tooth structure that is weak and susceptible to fracture.
- Restores the tooth to a healthy form and function.
- Eliminates areas that collect plaque that can cause tissue inflammation or infection.
- Prevents the progression of decay into the nerve.

Risks may include but are not limited to:
- Injury to the nerve tissue during removal of decay that may require removal of the nerve.
- Allergy to metal components.
- Hot, cold and/or pressure sensitivity.

Alternatives:
- Extraction of the tooth.
- No treatment. If treatment is not administered, tooth decay will continue to progress, likely resulting in pain and/or infection and/or the eventual premature loss of the tooth or teeth.

MORE INFORMATION ON BACK SIDE OF SHEET

Local Anesthesia
The administration of a local anesthetic by injection is routinely used in dental procedures to temporarily numb the treatment area to provide our patients with safe and comfortable dental treatment and is based on information provided in your medical history.

Risks may include but are not limited to:
- Discomfort at the injection site
- Prolonged numbness
- Muscle soreness in the area of the injection
- Allergy to the anesthetic solution or an adverse reaction to the anesthetic
- Possible interactions with prescription and non-prescription drugs, including supplements and illicit drug use.
- During the evaluation process, I will inform dentist of all prescription and non-prescription drugs that the patient is taking.

Alternatives
- No anesthetic
- Sedation or General Anesthetic

Consequences of no local anesthetic:
- Discomfort of varying degrees during treatment which may interfere with completion of treatment.

Removable/Fixed Appliances (occlusal guards, partial dentures, retainers)
Removable appliances may be appropriate for the replacement of missing teeth, stabilization of teeth position, and/or therapy for occlusion issues (such as the way a patient's teeth bite together).

Benefits of Appliances
- Replacement of missing teeth which restores the ability to chew effectively
- Stabilization of teeth position
- Maintain appropriate occlusion position and protection of restorations
- Correction of minor tooth position

Risks may include but are not limited to:
- Adaptation period for adjustment to wearing a removable appliance
- Several adjustments to the appliance to ensure the proper fit
- Food trapping around the appliance
- Future orthodontic treatment may still be recommended

Alternatives:
- No removable appliance

Consequences of no treatment:
- Limited chewing effectiveness
- Loss of stability of teeth that may result in movement of teeth
- Space loss for future teeth
- Excessive wear of teeth and restorations (fillings and crowns)

General risks include, but are not limited to:
Accidental aspiration or swallowing of dental materials or instruments
Sore areas on the lips, cheeks, tongue and gums

Patient Confirmation, Acknowledgement, and Consent:
I confirm that I have read the above and fully understand the treatment that could be recommended as well as the risks, benefits, alternatives, and consequences of no treatment. **An explanation of treatment along with a treatment plan will be presented when treatment beyond preventative care is recommended.** I have read and understand the benefits and limitations of comprehensive care. I agree to have my child follow all instructions provided to us by this office before and after any procedure. I will inform the dentist of any post-operative problems as they arise. Our failure to comply could result in complications or less than optimal results.

By signing this document, I acknowledge and accept the possible risks and complications of the described dental procedures.

Patient's Name | Date | Guardian's Name/Relationship to Patient | Signature

Practice Representative Signature/Name