



INFORMED CONSENT FOR PEDIATRIC DENTAL TREATMENT OF:

Patient Name

It is necessary for us as health professionals to obtain your consent for your child's planned dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand.

1. I hereby authorize Dr. Oshmi Dutta and/or his Associate and their hygienists/assistants to perform upon my child the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, analgesia, or radiographs.

In general terms, the dental procedures will include:

- a. Teeth cleaning, fluoride application, and any necessary X-rays
- b. Photograph, film, videotape, record and/or interview (may be used either internally or externally)
- c. Applying plastic "sealants" to the grooves of teeth
- d. Repairing diseased or broken teeth with fillings or crowns
- e. Treating infected teeth and/or gums
- f. Removal of one or more teeth

****I understand** that on some occasions treatment is subject to change once in the dental treatment chair. I authorize any necessary changes to be made by Dr. Dutta and/ or his Associates to do what is in the best interest of my child.

2. I have had explained to me by Dr. Oshmi Dutta and/or his Associate, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

3. Although their occurrence is extremely remote, some risks are known to be associated with dental procedures. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. Occasionally, a child may also chew/irritate his or her own cheek, lip, or tongue while numb. It is the responsibility of the parent to closely monitor children who are numb to decrease the risk of such complication.

4. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

5. **I understand** that should the patient become uncooperative during dental procedures with movement of the 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, stabilize the head and/or control leg movements.

6. **I further understand** that should the patient become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in an "immobilization wrap" or "papoose board" to prevent injury and enable Dr. Dutta and/or his Associate to safely provide the necessary treatment. Should the use of the wrap become necessary, you will be asked to sign the following statement:

I consent to the use of the stabilization wrap.

Signature: _____ Date: _____.

In general terms, the behavior management techniques during treatment will include:

- a. Tell, Show, Do
- b. Distraction
- c. Positive reinforcement
- d. Use of voice control to gain the attention of a disruptive child
- e. Use of physical restraint to safely accomplish necessary dental procedures. This may include hand and/or head holding, as well as an immobilization wrap (papoose).

The above behavior management techniques have been explained to me both verbally and in writing. I have had a chance to ask questions. I understand the what, when, how, and why of their use, and the risks/benefits/available alternatives.

5. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

6. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

7. I confirm that I have read (or it was read to me) and understand the information on the front and back of this form, and that all blanks were filled in, and all inapplicable paragraphs, if any, were stricken before I signed below. The proposed treatment has been explained to me, as have any alternative methods of treatment, and the advantages and disadvantages of each. I am advised that although good results are expected, the possibility and nature of complications cannot always be accurately anticipated. Therefore, there can be no guarantee as to the result of the treatment.

_____ I understand the treatment proposed and give permission to Dr.Dutta and/or his Associate(s) to complete any treatment needed and make any changes as needed.

_____ I refuse to give my consent of the proposed treatment and fully understand the consequences of not having the treatment done for my child.

Parent/Guardian

Date

Witness

Oshmi Dutta DDS, MS

Date