Informed Consent for Pediatric Dental Treatment

Chapel Hill Pediatric Dentistry

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1. I request and authorize the treatment and procedures on the PROPOSED TREATMENT PLAN FOR:
   Patient Name:_____
   Date of Proposed Treatment Plan:_____

2. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable to diagnose and/or treat the patient's dental problems.

3. I have informed the dentist of any allergies my child has to latex and/or lidocaine.

4. I understand that the usual and most frequently occurring risks or complication occurring from the planned treatment procedures and the use of local anesthesia 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, nausea, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness of the lip, tongue, chin, gums, cheek, and teeth, allergic reactions, referred pain, sensitivity, treatment failure, and delayed healing. I understand severe complications may require hospitalization.

5. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's PROPOSED TREATMENT PLAN and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no implied or expressed guarantees have been made to me concerning the results of the dental treatment that the patient will receive.

6. 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.

7. I understand that a cushioned mouth rest may be used to aid in resting the mouth in the open position. This is a safety device used to prevent tiring of the jaw muscles or accidental biting down on the handpiece.

8. 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 assistant(s) to hold the patient's hands, stabilize the head, and/or control leg movements.

9. I further understand that should the patient become uncooperative during dental procedures with excessive body movements, the patient may need to be restrained to prevent injury and enable the dentist to provide the necessary treatment. *(The parent/guardian will be verbally informed if restraint with a pedo-wrap (Velcro wrap) is necessary during treatment. The parent/guardian will be asked to assist the dentist in using that restraint if necessary.)*

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

11. I understand that post-operative instructions will be reviewed for the specific treatment rendered after the completion of the appointment.

12. I understand and agree to the philosophy of parental separation during the dental procedure. The idea is to allow the patient to focus on the doctor's instructions during the treatment.

13. I understand that nitrous oxide may be used during the procedure. Nitrous oxide is a sweet-smelling gas that allows for anxiolysis. Oxygen will be used at the end of the procedure to flush out any remaining nitrous oxide.

    X_____ AAPD recognizes N20/02 inhalation as a safe, effective technique to reduce anxiety, produce analgesia, and enhance effective communication between a patient and health care provider. Analgesia/anxiolysis is the diminution or elimination of pain and anxiety in a conscious patient. N20 raises the pain reaction threshold, reduces gagging, and increases tolerance for longer appointment. To avoid diffusion hypoxia, it is important to administer 100% 02 to the patient for 3-5 minutes after N20 administration.

14. I have had explained to me, and I 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.

15. I have had the opportunity to have all of my questions answered by Dr. Avni Rampersaud, Associates, and/or her staff prior to any operative dental treatment performed on my child.

16. I understand, to my satisfaction, the procedures to be performed, accept the possible risks, and consent to the treatment prescribed for the patient in the PROPOSED TREATMENT PLAN.

17. 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.

I confirm that I have read and understand this form, or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

You are receiving dental care during the events of a COVID-19 national emergency. Please be advised that there may be risk in being in the proximity of dentists, patients, or staff. We are taking precautions as recommended by the CDC, ADA and the NC State Dental Board to limit the spread of disease, yet there is still a possibility of transmission.

Signature of Person Consenting to Treatment:_____

Witness: _____ Date:_____