- ☐ CHILD DENTISTRY (PEDODONTICS):

  By initializing below, I understand that the following procedures are routinely used at this dental office, as well as being accepted procedures in the dental profession.

  A. POSITIVE REINFORCEMENT – Rewarding the child who portrays desirable behavior, by use of compliment, praise, a pat or a hug and/or a toy.
  B. VOICE CONTROL – Changing the tone and/or increasing the volume of the doctors, hygienists, or assistants voice may be used to gain the attention of a disrupted child.
  C. PHYSICAL RESTRAINT – Restraining the child's disrupted movements by holding down their hands, upper body, and/or legs by the use of the dentist's or assistant's hand or arm, or by the use of a special device (referred to as a "papoose board").
  D. NITROUS OXIDE – Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered though a mask placed over the child's nose. The parent/guardian must be available to escort the child home after the procedure, and observe their behavior throughout the day.

  I understand that with the use of an injection (used to numb the tooth for dental procedures) the possibility exists that the child may inadvertently bite the lip and or cheek causing injury to occur.

  I understand the need to return to the office, for evaluation, if my child experiences swelling and/or pain that does not go away after a sufficient time period.

  I understand the need to return to the office within three (3) months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

  Initials: _____

I understand that no guarantee or assurance has been given that the proposed treatment will be curative and/or successful to my complete satisfaction. I agree to cooperate completely with the recommendations of the doctor while I am under her care, realizing that any lack thereof could result in a less than optimum outcome.

I certify that I have had an opportunity to read and fully understand the terms and words within this document, including the opposing side of this document, and consent to the operation and explanation referred to or made. I understand that I am encouraged to ask questions, and have them answered to my satisfaction of understanding.

I understand these dental services are provided without discrimination based on race, religion, color, nationality, origin, sex, sexual orientation, physical or mental disability, age, or marital status and protects the privacy of each of our patients.

Patient Name (please print): _____

Patient /Guardian Signature: _____ Date: _____

Witness: _____ Date: _____