

## Pediatric Dental Arts Consent to Perform Dentistry

Initial \_\_\_\_ 1. I hereby authorize and direct Melissa Burruezo, D.M.D. to perform the following dental treatment or oral surgery procedures including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

- A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
- B. Application of protective "sealants" to the grooves of the teeth.
- C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
- D. Removal (extraction) of one or more teeth.
- E. Treatment of diseased or injured oral tissues (hard and/or soft).
- F. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

Initial \_\_\_\_ 2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

Initial \_\_\_\_ 3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

Initial \_\_\_\_ 4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

Initial \_\_\_\_ 5. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site) fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to the medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

Initial \_\_\_\_ 6. I also authorize the doctors to use photographs, radiographs and other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

Initial \_\_\_\_ 7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

Initial \_\_\_\_ 8. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Initial \_\_\_\_ 9. Has your child received the COVID-19 vaccination? Yes/No

Initial \_\_\_\_ 10. Is your child experiencing any of the following - dry cough, runny nose, sore throat, watery eyes, sinus pain/pressure that is unusual and not related to seasonal allergies, headaches, fatigue, weakness, loss of taste and/or smell? Yes/No If yes, please explain: \_\_\_\_\_

Initial \_\_\_\_ 11. Within the past 14 days, have you had a known exposure to any individual suspected or confirmed to have COVID-19 or who has traveled to a location after which self-quarantine is recommended? Yes/No

Initial \_\_\_\_ 12. I hereby state that I have read and understand this consent and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

Initial \_\_\_\_ 13. I further understand that this consent will remain in effect as long as I am a patient at Pediatric Dental Arts.

Patient's Name: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

Patient/Parent/Guardian