Pediatric Dentistry Orthodontics
TRUPKIN • WILENTZ • CHIZNER

GENERAL CONSENT FOR DENTAL PROCEDURE AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. State law requires us to obtain your consent to your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it. I hereby authorize and direct Dr. Trupkin, Dr. Wilentz, and Dr. Chizner Steinberg assisted by other dentists and/or dental auxiliaries of his/her choice, to perform upon my child (or legal ward for whom I am empowered to consent) the following:
2. In general terms the dental treatment or procedure(s) MAY INCLUDE:
A. Radiographs (x-rays) of the teeth and jaws (and intraoral/extra-oral clinical photographs)
B. Cleaning of the teeth and the application of topical fluoride.
C. Application of plastic "sealants" to the grooves of the teeth.
D. Use of local anesthesia to numb the teeth and tissues.
E. Treatment of diseased or injured teeth with dental restorations (fillings).
F. Replacement of missing teeth with dental prosthesis.
G. Removal (extraction) of one or more teeth.
H. Treatment of diseased or injured oral tissues (hard and/or soft).
I. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
J. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures. This entails a separate consent and parent will be notified prior to treatment.
K. Use of General Anesthesia to accomplish the necessary treatment. This entails a separate consent and parent will be notified prior to treatment.
L. Use of sedative drugs to control apprehension and/or disruptive behavior. This entails a separate consent and parent will be notified prior to treatment.
M. Other ____
3. Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form, an extracted tooth or gauze packing; injury to treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of subacute bacterial endocarditis (heart infection) following dental treatment exists, therefore antibiotics will be prescribed before and following treatment, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment and may require hospitalization. Additional risks include: _______________________

The nature and purpose of the treatment and procedures have been explained to me in general terms by Dr's Trupkin, Wilentz, and Chizner Steinberg. Alternate procedures or methods of treatment, if any have also been explained to me, as have their advantages and disadvantages, the risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I further authorize the doctor to perform other dental service(s) that in his/her judgment are advisable for my child or legal ward, with the exception of (if none so state.):____

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I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it by verbal and written notification.

Cancellation policy: I further understand that PDO reserves the right to charge a fee for missed or canceled appointments if a twenty-four hour notice has not been given. Please notify us if your child is sick, as this is not considered a true cancellation.

SUPPLEMENTAL COVID-19 INFORMED CONSENT

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that at PDO, we have always followed regulations and recommendations regarding sanitation and safety protocols. We have gone above and beyond the recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and will continue to do so.

In order to minimize risk, we at PDO are adjusting to new recommendations for our patients including but not limited to the following:

- Only the patient will be allowed in the office during visit.
- While receiving dental services, patients will be appropriately distanced from any other patients.
- All dental auxiliary staff will be wearing the appropriate personal protective wear (to protect patients and staff) as per CDC guidelines.
- All staff will have daily screening for symptoms or exposure to COVID-19

"Social Distancing" nationwide has reduced the transmission of COVID-19 (coronavirus). Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be exposed when receiving treatment in other healthcare facilities. Although we have taken additional measures to provide social distancing and disinfection/sterilization in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, and dental staff.

Although exposure is unlikely, do you accept the risk and consent to treatment?
Yes ___________ No_____________

Name of Patient: __________________________ Date: ___________
Parent/ Guardian Name: _______________________Relationship:_______________________

Signature of Parent/Guardian: _______________________________

By signing this consent below, I authorize Pediatric Dentistry and Orthodontics to escort my child without me being present throughout today's appointment.

Signature of Parent/Guardian: _______________________________