south shore pediatric dentistry

CONSENT FOR TREATMENT WITHOUT THE PRESENCE OF PARENT/ LEGAL GUARDIAN

Patient Name: _____

My name is _____and I am the legal

guardian/parent of the child named above. I authorize_____
(Name of accompanying adult)

to accompany my child for his/her treatment today. I request and authorize the following dental treatment(s) by Dr.

Sally Hua, Associates and staff in my absence:

- Exam/ Consultation YES / NO
- Cleaning and Fluoride varnish YES / NO
- Dental x-rays YES / NO
- Sealant YES / NO
- Composite resin fillings YES / NO
- Extraction YES / NO (Please fill out additional form)
- Nerve treatment YES / NO
- Stainless steel crowns YES / NO
- Space maintainer YES / NO
- Local anesthetic YES / NO
- Nitrous oxide sedation YES / NO (Please fill out additional form)
- Orthodontic visit YES / NO

Please initial the lines below:

___ I understand and give permission for minor changes to the treatment plan should they become necessary to complete the treatment in the best interest of my child. I understand I will be responsible for all costs associated with additional treatment. I understand that I will receive a refund if there is a fee difference in my favor. Our office will make effort to inform you the changes to the treatment plan as soon as possible.

___ I understand that the goal of this office is to provide dental treatment in the best interest of my child with warmth, care, persuasion, gentle behavior techniques , child friendly dental terms, humors and voices in variable tones.

___ I understand and authorize protective stabilization such as lap-to-lap exam or knee-to-knee exam with the above named accompanying adult. Knee-to-knee exam is a technique used for a very young child, or child who lack cooperation due to medical reasons, for their teeth to be examined, cleaned, and fluoride varnish application, ART (Atraumatic Restorative Technique)

___ I understand that should the patient become uncooperative during dental treatment (emotional upset, high-hands, grabbing doctors or staff hands, movement of head, arms and/or legs), **treatment cannot be safely continued and may be aborted**. Other treatment options will be discussed with me to complete the treatment in the best interest of my child.

___ If an employee of the practice is accidentally contaminated with your child's body fluids (blood, saliva, vomit, mucus, etc.) your signature on this form gives permission for us to get your child's blood drawn for infectious disease status as defined by Massachusetts law and authorizes the testing facility to release the test results to the injured employee.

If at any time you have questions, please feel free to ask our staff or call our office. We are here to help in anyway we can. We appreciate you entrusting your child's dental health to us.

My signature on this form affirms that I understand these policies, have had the opportunity to have questions answered to my satisfaction and will comply with all items. I also agree to be responsible for all account balances.

Signature: Date: