Montgomery County Department of Health & Human Services

DENTAL TREATMENT INFORMED CONSENT FOR MINORS

One of our most important parental policies is to "inform before we perform." Before we begin treating your child, we ask your permission for dental screenings/assessments, periodic dental examinations, x-rays, dental cleanings, fluoride applications and dental sealants. We also need your permission to perform dental treatments which include dental restorations (stainless steel crowns and fillings) and/or appliances as needed to return all teeth to health and proper function, using local anesthetic and a comfortable mouth prop, when needed. The purpose of all these procedures is to gain and maintain dental health, and we expect good results, although no guarantees as to the results may be given.

Although our goal is the best oral health for your child, there are some slight risks involved in getting to that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling and infection. But ignoring a known dental problem has an even greater risk. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

A visit to the dental clinic presents the young child with new and unfamiliar experiences. It is completely normal for some children to react to these new experiences by crying. All efforts will be made to gain the confidence and cooperation of our young patients by warmth, humor, gentle understanding and friendly persuasion. High quality dental care for children is our goal. Quality care can be made very difficult or even impossible, by lack of cooperation. Behaviors that can interfere with proper dental treatment are hyperactivity, resistive movements, refusing to open the mouth or keep it open, and even aggressive or physical resistance to treatment. Aggressive or physical resistance to treatment can be screaming, hitting, kicking, and grabbing the dentist's hands or grabbing our sharp dental instruments.

There are several behavior management techniques that are used in our office to help children get the quality dental care they need. Let us tell you about them:

a. TELL-SHOW-DO is the use of simple explanations and demonstrations, geared to the child's level of maturity.
b. POSITIVE REINFORCEMENT is rewarding the helpful child with compliments, praise, a hug or a prize.
c. VOICE CONTROL is getting the attention of a noisy child by using firm commands and varying tones of voice.
d. LAUGHING GAS/ NITROUS OXIDE is another safe way to provide dental treatment to mildly frightened, but helpful children. Laughing gas calms children, but does not put them to sleep or numb their teeth. It has few side effects and lasts only as long as the gas is being given through the nose mask. On rare occasions, the gas can cause an upset stomach and vomiting.

Beyond these techniques, a child with disruptive behavior may need dental treatment with sedation or general anesthesia with an anesthesiologist and will be referred for this treatment if needed.

PLEASE FEEL FREE TO ASK ANY QUESTIONS ABOUT ANY OF THE INFORMATION REVIEWED ON THIS DOCUMENT

I have read and understand this information on behavior management. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatments in terms appropriate to their age. If any treatment other than the above is needed, it will be discussed with me before beginning such treatment. I understand that I may refuse any and all of the above treatments or procedures. I can do this by drawing a line through the objectionable part and writing my initials next to the portion to which I refuse consent.

This consent will remain in full force unless withdrawn in writing by the person who has signed on behalf of this minor patient.

_____	_____	_____
PRINT CHILD'S NAME	PARENT/GUARDIAN SIGNATURE	DATE

Montgomery County Department of Health & Human Services

ATTESTATION OF PARENTAGE OR LEGAL GUARDIANSHIP FOR MINORS

_____ _____

PRINT CHILD'S NAME CHILD'S DATE OF BIRTH

I _____ affirm, under penalty of perjury, that I am:
Parent/Legal Guardian Printed Name

1. The natural or adoptive parent of the above-named minor child and there is no court order limiting my medical decision-making authority with respect to the minor; or
2. I have been designated by a court of competent jurisdiction as the legal guardian of the above-named minor child and I have the authority under said order to make medical decisions on behalf of the minor

_____ _____

Parent/Legal Guardian Signature Date

AUTHORIZED PERSONS

Please list authorized persons whom we may discuss your child's Protected Health Information (PHI) and who may bring them to appointments other than parents or legal guardians. Photo identification will be required by the authorized person for verification at the time of the appointment. By signing below, I confirm the authorized person is age 16 or older. Please notify us if you desire to remove a name from this list in the future.

1. _____ Date ____ /____ /____ Relationship: _____ □ PHI □ APPT

2. _____ Date ____ /____ /____ Relationship: _____ □ PHI □ APPT

3. _____ Date ____ /____ /____ Relationship: _____ □ PHI □ APPT

This authorization shall remain effective:

□ One (1) year from date signed below

OR

□ Until_____ (Month, Day, Year)

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Montgomery County DHHS Dental Program prior to this date.

_____

Parent/Legal Guardian Printed Name

_____ _____

Parent/Legal Guardian Signature Date