DENTAL PARENTAL INFORMED CONSENT FORM

CHILD'S NAME:_____ BIRTH DATE:_____ SCHOOL:_____

Your child has recently, been examined by a Dentist of the Oral Health Partnership, and is in need of some basic dental care. This form will explain the care that your child needs, and requests your permission to provide that care. If the form is **not** returned, your child will receive **no** restorative dental care other than emergency care to relieve immediate pain. (Note the original consent form allows preventive care only) This information is provided to help you understand the treatment needed for your child. Before beginning, the following explanation of treatment is provided so that you are well informed and confident that you wish to proceed.

Treatment Plan

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- **Dental Fillings: _____Tooth/Teeth**

  Decay dissolves the tooth and, if not treated, will result in an abscessed tooth causing pain and infection. The dentist will remove the decayed and weakened part of the tooth and replace it with a silver alloy or tooth colored material to strengthen the tooth. A local anesthetic will be used that will "numb" the area being treated for two or three hours. If the decay area is too large, it may require a **Stainless Steel Crown.** I understand the placement of fillings may render the involved teeth sensitive to hot and cold temperatures and / or pressure for an extended period of time.

- **Stainless Steel Crown: _____ Tooth/Teeth**

  If a tooth is badly destroyed by decay and / or a filling will not stay in place. The tooth is trimmed around the sides and a preformed crown or "cap" is placed over the tooth to protect it from breaking. As with fillings, the area is usually treated with an anesthetic to help the child remain comfortable for one or two hours. **Stainless Steel Crowns are silver in color.** The tooth and gum tissue afterwards may be sore after stainless steel crown placement. You may give the child Tylenol and supervise warm salt water rinses as needed. Please stay away from sticky candies as this may pull off the crown.

- **Nerve or Pulp Treatment: _____ Tooth/Teeth**

  When the decay or infection progressed far enough that the tissue **inside** the tooth is infected, all or part of that infected tissue must be removed and a special filling placed in order to keep the infection from spreading to other parts of the body. The treatment can take up to two visits during which an anesthetic will be used. Pain or swelling after this work is possible and usually minor. Antibiotics may be used to control possible infections. After treatment, a filling or stainless steel crown will be placed to help strengthen the tooth and keep it from breaking.

- **Sealants _____Tooth/ Teeth**

  Back teeth have deep grooves and pits in which decay usually starts. The dentist or hygienist will "seal" the grooves with a plastic coating to help prevent the decay from starting. No anesthetic is needed.

- **Extraction or Removal of the Tooth: _____ Tooth/Teeth**

  If the infection has spread too far to rebuild the tooth, it is often best to remove the tooth to prevent the infection from spreading. After "numbing" the area with anesthesia, the tooth is removed and gauze is placed. Biting on gauze usually will stop the bleeding. Pain or swelling after this work is possible and usually minor. Nothing bubbly in 48 hours. No vigorous rinsing for 48 hours.

- I understand that should the patient become uncooperative during dental procedures with movement of head, arms and/or legs, dental treatment cannot be *safely* provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and or control leg movements. Procedure may not be continued or completed if safety and cooperation cannot be maintained. Your child may need to be referred to a specialist which is your responsibility.

- I understand that the administration of local anesthetic may cause an untoward reaction of side effects, which may include, but are not limited to temporary bruising, hematoma, cardiac stimulation, muscle soreness or rarely, permanent numbness.

- I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatments procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

- I consent to the above treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.

  *If you have any questions regarding the care needed your child, please call the office at **920-965-0831** and they will be happy to answer your questions. There may be minor changes once treatment has been started. You will be notified of only major changes.

  As the parent or guardian, by signing below you authorize the OHP dentist and dental auxiliary to provide these services for the child named. If the form is not returned, no care will be given except emergency care.

- I further acknowledge and attest that I have full legal authority to authorize and consent to the foregoing in the patient's best interest. Further that this consent will be valid for one year from the date of signature or execution of this document unless revoked by me in writing. **PLEASE SIGN AND RETURN IMMEDIATELY.**

Legal Guardian_____**Date**_____