sprout
PEDIATRIC DENTISTRY
& ORTHODONTICS

General Consent for Treatment

I consent to **routine dental procedures** for my child such as: dental exams, cleanings, x-rays, sealants, silver diamine fluoride (SDF), fluoride application, local anesthesia (numbing), and fillings.

I understand that I may be requested to provide additional verbal and/or written consent for procedures beyond routine care, such as, nitrous oxide (laughing gas), crowns/caps, pulpal therapy, extractions, and active and/or passive restraint.

The practice of pediatric dentistry involves the use of various **behavior guidance techniques** to ensure a safe and positive environment for the patient. Techniques commonly used in our office include: positive reinforcement, modeling/role playing, explanation of procedures with "tell-show-do," voice control, and the administration of nitrous oxide (laughing gas). A mouth prop may also be used to assist the patient in keeping the mouth open during lengthy procedures.

I consent to routine procedures necessary for **orthodontic examination**, such as x-rays, intra-oral and extra-oral photographs (pictures of the face and teeth), and impressions (molds) of the teeth. Additional written consent will be required for patients who wish to undergo orthodontic treatment.

I understand all dental procedures and the reasons for such procedures, as well as the risks, benefits, and alternatives will be explained to me. I acknowledge that I have the right and responsibility to ask questions regarding any techniques performed by the doctor.

I consent to the above listed procedures and behavior guidance techniques for the purpose of rendering dental care to my child. I have had the opportunity to ask questions, and all my questions have been properly addressed and answered.

Please list any procedures (if any) that are **not approved** for use in treating the patient: _____

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I understand that Sprout Pediatric Dentistry & Orthodontics reserves the right to dismiss my child as a patient when it is deemed that my child's dental needs have exceeded the scope of pediatric dentistry.

Signature of parent/guardian: _____

Print name: _____

Child's name: _____ Date: _____