Gary D. Sabbadini, D.D.S., A.P.C.

Dentistry for Children & Young Adults

Diplomate, American Board of Pediatric Dentistry
Fellow, American Academy of Pediatric Dentistry
Fellow, International College of Dentists
Fellow, Pierre Fauchard Academy

CONSENT TO DENTAL PROCEDURE(S) AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Patient Name: _____

State law requires us to obtain your consent for your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it to you.

I hereby give permission to Gary D. Sabbadini, DDS and his respective staff to render all necessary dental services (including oral and dental radiographic (x-ray) examination and diagnosis, dental prophylaxis (cleaning) and topical fluoride treatment) and to use such methods and agents as they see fit for the child name on this form. I understand that no treatment will be started until the recommended treatment, time involved, and financial investment has been discussed with me or my representative by either Dr. Sabbadini or one of his staff members, at which time I may void this permission if I so choose. Furthermore, I will be responsible for any bills incurred on this child for dental treatment.

_____ _____

Signature of Parent or Legal Guardian ***Date***

INFORMED CONSENT FOR SPECIFIC PROCEDURES

I hereby authorize and direct Dr. Sabbadini and/or other affiliated dentists or dental auxiliaries of his choice to perform upon _____, my child (or legal ward), the following dental treatment or oral surgery procedures:

<u>Initial Below</u> (Signify approval by initialing in the space provided)

_____ ☐ A. Application of sealants to the grooves of the teeth
_____ ☐ B. Use of local anesthesia to numb the teeth and tissues
_____ ☐ C. Treatment of diseased or injured teeth with dental restorations
- Composite Resin (White) _____
- Amalgam (Silver) _____
- Stainless Steel Crowns _____
- Zirconia (White) Crowns _____

_____ ☐ D. Treatment of injured or infected pulps (nerves) of teeth
_____ ☐ E. Removal (Extraction of teeth)
- Primary (Baby) _____
- Permanent (Adult) _____

_____ ☐ F. Space maintenance of missing tooth/teeth with dental prosthesis
_____ ☐ G. Treatment of diseased or injured oral tissues (Hard and Soft)
_____ ☐ H. Treatment of malposed (crooked) teeth and/or oral developmental and growth abnormalities
_____ ☐ I. The use of physical restraint or restraining devices to safely accomplish the dental procedure(s) **(only to be used if absolutely necessary)**:
- Papoose Board _____
- Pillow Case (Arms) _____

_____ ☐ J. Nitrous Oxide/Oxygen to alleviate anxiety

.....**CONTINUE TO SIDE TWO, PLEASE READ AND SIGN**.....

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I understand that during the course of the planned procedure(s), unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those contemplated. Therefore, I further authorize Dr. Sabbadini and/or other dentists or staff to perform other dental service(s) that, in their judgment, are advisable for my child or legal ward, with the exception of: (*if none, leave blank*) _____

The nature and purpose of the treatment and procedures have been explained to me in general terms by Dr. Sabbadini and/or his staff. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, 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; therefore, there can be no guarantee expressed or implied either as to the result of the treatment or as to the cure. I understand that it is my responsibility to ensure that my child comes in for routine examinations to monitor his/her oral health and ensure that any restorations/appliances placed by Dr. Sabbadini are still functioning properly.

Risks

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complication associated with pediatric dental treatment is nausea following anesthesia (this includes nitrous oxide, oral sedation, and IV sedation). Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, tooth discoloration, vomiting, allergic reactions, swallowing or aspiration of dental materials, extracted teeth or gauze packing, injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. I further understand and accept that complications may require additional medical, dental or surgical treatment and may require hospitalization.

Prophylactic Antibiotics

For children with heart disease, there is a risk of infective endocarditis (heart infection) following dental treatment; therefore, antibiotics may be prescribed before and after treatment to minimize risk. The current recommendations of the American Heart Association and the American Academy of Pediatric Dentistry will be followed as a guide.

Use of Records and Photographs

I authorize Dr. Sabbadini to use photographs, radiographs, treatment records and other diagnostic materials for the purpose of teaching, research and scientific publications with the assurance that my child's identity will remain confidential. _____ (*Initial if declining the use of records and photographs, otherwise leave blank*)

Understanding This Form

I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask any questions I might have, and that all questions about the procedure(s) have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I 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.

Patient's Name _____
For whom consent for treatment is granted

Name of Parent/Guardian _____ **Relationship to Patient** _____

Signature of Parent or Guardian _____ **Date** _____

_____ _____
Signature of Dentist Obtaining Consent **Date**

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