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

Welcome to our practice! We appreciate the opportunity to apply our care, skill and judgment to your child's total dental needs. Recognizing that our office represents a new experience for you and your child, we offer the following information about our office.

- We, along with the American Academy of Pediatric Dentistry, American Dental Association, and the American Academy of Pediatrics recommend that children have their first dental examination by either the time their first tooth erupts or 12 months of age. Many dental problems can be avoided by early anticipatory guidance.
- We are deeply committed to the total health and well being of your child and to the ideals of preventive dentistry.
- We maintain state-of-the-art quality by attending numerous continuing education courses yearly.

Before the First Visit

- Please discuss the positive aspects of dentistry with your child. Convey good feelings to your child about dental visits being a part of growing up. Rather than, "The dentist will not hurt you," you might say, "The dentist will be very gentle and take good care of you."
- Expect your child to react well and enjoy the first visit to our office and chances are he/she will do exactly that.
- The appointment time is reserved especially for your child**. A cancellation or change should be made *at least 48 hours* in advance to avoid a set up fee equivalent of $50.00. We appreciate this consideration so we may serve other patient(s) who need an appointment. Please complete the enclosed health history form and bring it with you for the first appointment.**

The First Visit

- Our staff will review the health history and other office forms with you. Your child will be introduced to our dental team and allowed time to see the office and become comfortable before the examination.
- We encourage you to stay with your child during the initial examination. Following the exam, any findings and recommendations will be discussed with you. You will be given an estimate of the cost of any recommended treatment.
- Radiographs (X-rays) will be taken to determine your child's present dental condition. If desired, your child's teeth will be cleaned and oral hygiene instructions given. Dr. Sabbadini will examine the hard and soft tissues of the mouth and perform a head and neck examination. Any needed treatment will most likely be scheduled for a future appointment.
- While we want you to accompany your child during his/her appointment, we reserve the right to request that you stay in the reception area if we feel that your child will do better by him/herself. Our purpose is to gain your child's confidence and provide a positive dental experience. Also, please do not leave the office during our children's appointments. This is to ensure that we are able to talk with you should anything change during your child's appointment and so your child will not have to wait for you should we get done early.
- If your child cries, it is because children are often afraid of anything new and strange, and crying is the normal reaction to that fear.

Dental Health Education

During the hygiene (cleaning) appointment, our staff will be able to evaluate your child's present home preventive care and exchange ideas that will be helpful to your child's and, hopefully, your whole family's dental health. We're pleased to offer this service at no extra charge as part of our regular hygiene appointments as we strive to teach your child dental health concepts and cleaning techniques that will assure a lifetime of good oral health. Through education, it is our intent to prevent dental disease and serve your child in the best manner possible. Dr. Charles Mayo of the Mayo Clinic emphasized the connection between bodily health and oral health when he said, "**Preventive dentistry can extend human life ten years."**

1500 Tara Hills Drive • Suite 100 • Pinole, CA 94564
(510) 724-4400 (Office) • (510) 724-4402 (Fax)
www.PinolePediatricDentist.com

Accidents

Please call our office at 510-724-4400 or Dr. Sabbadini at 925-286-4187 as soon after the accident as possible, and we will see your child immediately if necessary. If a tooth is knocked out, do not wash it. If possible, replace the tooth in the socket. If this is impossible, transport the tooth in milk or in the patient's mouth. Call our office immediately. The first 30 minutes are critical to saving the tooth. Children are frequently subject to accidents. In order to accommodate an injured child, our schedule may be delayed. Please accept our apologies ahead of time should such a delay occur during your child's appointment. Understand we will do exactly the same if your child is ever in need of emergency care.

Payment of Fees

- **Please be aware that the parent or guardian bringing the child to our office is legally responsible for payment of all charges. Duplicate statements will not be sent to other parties.**
- Your estimated payment is due at each appointment as service is rendered and can be made by cash, check, Visa, MasterCard, Discover, or American Express.
- For our patients with dental insurance, we will accept payment for further treatment directly from your insurance company; however, we ask you to pay non-covered fees (co-payment) as service is rendered. If we do not receive payment from the insurance company within 75 days after the completion of treatment, you will be expected to pay for all dental services. In the event of duplicate payment, you will be reimbursed. **Please provide our staff with all pertinent insurance information, so that we may file the insurance for you. Please notify us immediately if there are any changes to your coverage.**
- If you request that your child's treatment be pre-authorized by your insurance company, there may be a charge to cover the time and expense of providing this service. If this applies to you, please ask one of our staff.
- Questions regarding your account may be directed to our office staff.

Infectious Disease Control

When you visit our office, you will observe the many measures practiced by the doctors and staff to ensure your child's protection from contact with bacteria and viruses. Special equipment such as ultrasonic cleaners and steam and chemical sterilizers are used routinely. The use of many disposable instruments and materials, masks, gloves and protective eyewear guard against cross-infection. You child's overall health and well being will always be a top priority in our office.

We sincerely trust that you and your child will find visits to our office to be comfortable and rewarding. We always appreciate your referral of family and friends to our office.

If you ever have questions, please feel free to call our office. We are here to serve you. We appreciate you entrusting your child's dental care to us.

Appointment Reminder

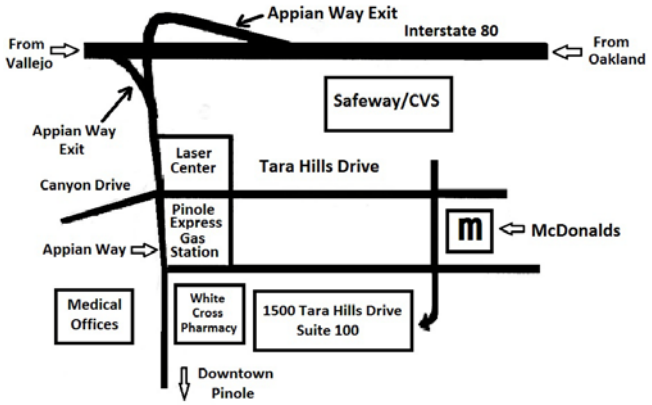
_____

Has an appointment

☐ Monday ☐ Tuesday
☐ Wednesday ☐ Thursday
☐ Friday

Date _____

Time _____



If you are unable to keep this appointment, please give us **48 business hours notice** so that the time may be given to another child.

1500 Tara Hills Drive • Suite 100 • Pinole, CA 94564
(510) 724-4400 (Office) • (510) 724-4402 (Fax)
www.PinolePediatricDentist.com

What To Expect During Your Child's Visit

Dear Parents,

Our office is dedicated to providing the highest quality dental care for your child. We strive to make your child's experience as positive and enjoyable as possible with their psychological and physical safety being paramount in importance. Your presence is requested during visits because we feel most children are more comfortable with a parent back with them and, medico-legally, we need to protect ourselves from any allegations or misunderstandings with an unattended child.

During your child's treatment, we will be utilizing several behavior management techniques. First and foremost is one called "tell-show-do." In this technique, we describe what we will be doing in child-friendly language, we show them what we'll be using, and then we do it. When explaining things to children, we use language that they can understand: "shot" becomes "medicine placed next to their tooth," "drill" becomes "whistle brush," "rubber dam" becomes "rubber raincoat," etc. We do ask that you refrain from over preparing your child for their dental visit. Just tell your child that they are coming in to have their teeth fixed, looked at, cleaned, etc. and we will explain the rest.

When sitting with your child, we ask that you sit quietly (the doctor likes to talk so he may engage you in conversation if your child is doing well). You are there to support your child and to hold their hand but we need their undivided attention when we give them direction (i.e. they need to listen to us). If you are talking with your child, they will listen to you and not to the doctor or the assistant. If we are to safely and efficiently complete treatment, your child needs to be able to respond to our prompts. During treatment, we may ask you to hold their hands and/or legs if your child is having a difficult time sitting still. This is for their protection and to allow us to complete the treatment. We may ask you to remove their shoes to avoid being kicked. Throughout their visit, we will constantly use positive reinforcement to acknowledge what they are doing well. You might hear us say things like, "You're doing a great job of holding still" or "Thank you for listening and keeping still." We find that this helps many patients tolerate treatment.

Occasionally, we may need to turn the television off to gain their attention if we are not getting their cooperation. If your child begins to become uncooperative or is crying or yelling uncontrollably, we may remove the nitrous oxide/oxygen mask and place it over their mouth. This serves two purposes. First, it quiets the child by muffling their voice which gives the doctor a chance to be heard. Second, it forces the child to breathe the nitrous oxide/oxygen which may help to calm them down. The doctor may also need to raise his voice so that he can be heard over your child's crying or screaming. This is not intended to frighten your child, nor is it done out of anger. It is simply to try to calm them down so that treatment can be safely completed. If your child still does not calm down, the doctor may ask you to leave the room as some children are more cooperative without their parent in the room.

Remember, crying is a normal consequence of a child's fear. It doesn't mean that they are in pain. Every effort is made to ensure that your child is comfortable throughout the procedure. Some children respond to vibration or noise as if it is pain. If we don't think your child has had enough local anesthetic, we will certainly give them more. Please don't ask your child if it hurts because the power of suggestion may make them think it is hurting or should hurt.

Please understand that there is no magic in what we do. We are more efficient and patient than most dentists. Our biggest asset is our ability to talk with your child and our behavior management techniques are intended to facilitate communication. The alternative to utilizing these behavior management techniques is to either restore your child's teeth when they are older and more cooperative or to treat your child via either oral or intravenous sedation. If you have questions about any of these techniques, please ask the doctor or staff. Remember, we both have the same goal: the safe and efficient care of your child's mouth.

Sincerely,

Gary D. Sabbadini DDS

Gary D. Sabbadini D.D.S. **HEALTH HISTORY**

Diplomate, American Board of Pediatric Dentistry

Date: _____ Update: _____

PERSONAL

Child's Full Name_____ Age_____ Birth date_____

Nickname (if any) _____ Sex Female Place of Birth _____

What is your child most interested in? _____

Brothers, names and ages _____ Sisters _____

Is your child adopted? Y O N O Does your child know? Y O N O

Child's pediatrician or physician _____ Telephone # _____

Who may we thank for referring you? _____ Child attends what school? _____

MEDICAL

Has your child had any of the following medical problems? *Check Yes (Y) or No (N)* – **discuss below if necessary**

Allergies to drugs or foods	Y O N O	Ear Infections	Y O N O	HIV+/AIDS	Y O N O
Asthma or lung problems	Y O N O	Handicaps or disabilities	Y O N O	Operations or Hospital/ER stays	Y O N O
Blood transfusions	Y O N O	Heart defect (congenital)	Y O N O	Learning disabilities	Y O N O
Cancer	Y O N O	Heart murmur	Y O N O	Rheumatic Fever	Y O N O
Convulsions or epilepsy	Y O N O	Hemophilia or abnormal bleeding	Y O N O	Trauma to mouth or face	Y O N O
Developmental delay	Y O N O	Hepatitis	Y O N O	Tuberculosis (TB)	Y O N O
Diabetes	Y O N O	High fevers	Y O N O		

Other medical problems: _____

Please discuss problems further, if necessary: _____

_____

_____

Has your child had any unfavorable reactions to medications or anesthetics (including the operating room)? Y O N O

Is your child currently taking any medications? Y O N O What kind? _____

Does your child have any breathing problems? Y O N O Breathes primarily through nose or mouth? _____

Does your child snore? Y O N O Does your child have frequent sore throats? Y O N O

HABITS

Does your child have or had any of the following habits?

Thumb or finger sucking	Y O N O	Pacifier use	Y O N O	Nail biting	Y O N O
Lip sucking or biting	Y O N O	Biting hard objects	Y O N O	Tooth grinding	Y O N O

Did your child use a bottle? Y O N O If yes, when did he/she stop? _____

Does your child currently use a bottle? Y O N O If yes, how often during the day? _____

Is the bottle used at night? Y O N O What is your child drinking? _____

Does your child currently nurse? Y O N O Does your child nurse at night time? Y O N O

FAMILY DENTAL HISTORY

Has Mother/ Father had a lot of decay? Mother _____ Has Mother/ Father had orthodontic care? Mother _____

Does Mother/Father have gum disease? Mother ___ Does Mother/ Father have TMJ problems? Mother _

CHILD'S DENTAL HISTORY

Has your child seen a dentist before? Y O N O

If yes, the approximate month and year of last visit: _____ Where? _____

Has your child had any unfavorable experiences in a dental or medical office? Y O N O _____

Does your child currently have any dental problems (pain, infection, or orthodontic problems, etc.)? Y O N O

If yes, please explain: _____

How often does your child brush his/her teeth per day? _____ Do you help brush? Y O N O

How often does your child floss? _____ Do you help floss? Y O N O

How do you think your child will act today towards the dentist? _____

Purpose of today's dental visit _____

_____

Examining Doctor's Initials _____ Date _____

(OVER) ⇒

PARENT INFORMATION

FATHER
Name _____
Home Address_____
_____
Home Phone _____
Cell Phone _____
Employer's Name _____
Occupation _____
Employer's Phone _____
Employer's Address_____
_____
DOB_____ Driver's License # _____
SS# _____-____-_____
E-mail: _____

MOTHER
Name _____
Home Address_____
_____
Home Phone _____
Cell Phone _____
Employer's Name_____
Occupation _____
Employer's Phone _____
Employer's Address_____
_____
DOB_____ Driver's License # _____
SS# _____-____-_____
E-mail: _____

Name of Parent/Guardian that child lives with _____
Name of Parent/Guardian financially responsible _____
Best number to call to remind you of your child's appointment _____

In the event of an emergency, whom should we contact?
Name:_____Relationship:_____Phone:_____
Name of nearest relative not living with child:_____Phone:_____

DENTAL INSURANCE:

PRIMARY
Responsible Party _____
Carrier Name _____
Carrier Address_____
_____
Carrier Phone _____
Group # _____

SECONDARY
Responsible Party _____
Carrier Name_____
Carrier Address_____
_____
Carrier Phone _____
Group # _____

I (the parent) understand that the information I provide on this health and information form is essential to determine my child's dental needs and the provision of dental treatment; I understand that if any changes occur in my child's health, I am to report it to the doctor or his staff as soon as possible. I have read and understand each question, I have answered all of them truthfully and to the best of my ability; and I have discussed my child's health history with the doctor.

_____ _____
Parent/Guardian Signature Dentist Signature

I authorize the use of radiographs, study models, photographs, and video recordings of my child's treatment for presentations or publications of the doctor.

_____
Parent/Guardian Signature

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**.....

1500 Tara Hills Drive • Suite 100 • Pinole, CA 94564
(510) 724-4400 (Office) • (510) 724-4402 (Fax)
www.PinolePediatricDentist.com

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**

1500 Tara Hills Drive • Suite 100 • Pinole, CA 94564
(510) 724-4400 (Office) • (510) 724-4402 (Fax)
www.PinolePediatricDentist.com

FINANCIAL ARRANGEMENTS

Financial arrangements are both necessary and beneficial in maintaining a sound professional relationship. We wish to inform you of our office policy in this regard.

1. On the initial visit, payment for service is due at the time service is rendered unless payment arrangements have been approved in advance by our staff.
2. Parents or guardians are responsible for all charges incurred at each visit.
3. Returned checks and delinquent balances will be subject to additional late fees and interest charges of 1.5% per month. You are also responsible for all costs associated with collecting past due balances.
4. We accept cash, checks, Visa, MasterCard, Discover, American Express, debit cards and offer health care financing for those who qualify.
5. **We understand and agree that should we fail to have our child arrive at his/her agreed upon appointment time without notifying Dr. Sabbadini or his staff at least 48 business hours prior to that agreed upon time, that we shall pay the "set-up" and sterilization fee ($50.00).**

IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding your insurance coverage can be a challenge. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company's budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy's exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. Re-filing your insurance a second time within 60 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time the service is delivered (i.e. your "co-pay").
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium your employer paid for insurance - not our fees or recommended treatment.
4. Assuming responsibility for payment if the insurance company does not pay our office within 75 days.
5. Immediately informing our office of any changes in your insurance coverage or employment.
6. If you request that your child's treatment be pre-authorized by your insurance company, there will be a charge to cover the time and expense of providing this service. If this applies to you, please ask one of our staff.

Thank you for taking the time to read this. Sign the space below and if you have dental insurance, please have your insurance card ready for us to copy for our records.

I hereby authorize Dr. Sabbadini to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Sabbadini. I understand I am responsible for any unpaid balance on my/my child's account.

_____ _____

Signature of Patient/Insured **Date**

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account rather than waiting for us to call you or having to resort to sending your account to a collection agency. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

Gary D. Sabbadini, D.D.S., A.P.C.
Diplomate, American Board of Pediatric Dentistry
1500 Tara Hills Dr. #100 • Pinole, CA 94564 • (510) 724-4400

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

DENTAL TREATMENT AGREEMENT

Patient Name: _____ Date: _____

- We, the undersigned, acknowledge and understand the treatment plan, including all dental work and medications being given to our child, treatment expectations, and treatment fees that have been presented to us by Dr. Sabbadini and/or his employed staff. We agree that the treatment plan was explained to us to our satisfaction, that we were encouraged to ask questions, and that all our questions were answered to our satisfaction. We also understand that if we should have any further questions that we are encouraged to contact Dr. Sabbadini and/or his staff for answers.

- Because of the amount of time being set aside to treat your child, we require that payment arrangements be made for the total cost of treatment before the appointment. You will be given an estimate for the full treatment based upon the doctor's examination. This estimate may change if your child's treatment changes. If you have insurance, our office will provide billing as a courtesy and will wait for insurance payment for up to 75 days. Your estimated co-payment is due at each dental visit. You are responsible for any remaining balance that is unpaid by your insurance company as previously outlined on your Financial Arrangement form.

- Pre-Payment & Deposit Policy: It takes great effort, time, and coordination to schedule our patients. Therefore, we require that a deposit of $50 or more (depending on the amount of time set aside) be paid prior to scheduling your child's treatment appointment. This deposit is part of your estimated co-payment and is non-refundable. Your child's estimated co-payment is due the day of your child's appointment. You are required to give our office at least 48 business hours notice prior to rescheduling your child's appointment. If we are not provided this courtesy, you may forfeit your entire deposit.

- We understand that we are not to leave the office during our child's appointments unless authorized by Dr. Sabbadini. This is to ensure that Dr. Sabbadini and/or the office staff are able to inform you of any treatment changes and get your written consent should anything change during your child's appointment. We also don't want your child to have to wait for you should we get done early.

- We acknowledge that the patient listed on the "Patient Name" line above is the patient in question and that we are the patient's parents and/or legal guardians.

- We acknowledge that we have been informed that the ***California Dental Materials Fact Sheet*** is available to read/download on the office website at www.PinolePediatricDentist.com.

- We acknowledge that we have been informed that the ***Notice of Privacy Practices*** is available to read/download on the office website at www.PinolePediatricDentist.com.

_____ Date: _____

Parent or Guardian Signature

1500 Tara Hills Drive • Suite 100 • Pinole, CA 94564
(510) 724-4400 (Office) • (510) 724-4402 (Fax)
www.PinolePediatricDentist.com