PetitSmiles
PEDIATRIC DENTISTRY

Initial Exam and X-ray Consent

Today's Date: .....
month/day/year

Patient's Name: ..... Date of Birth: .....
First Last month/day/year

Welcome to our office!

In order for us to provide your child with the best possible care, we ask that you carefully read the following and sign your approval:

a) I give Dr. Carla Vanessa Ruiz and her staff authorization to take any x-rays, records, and photographs deemed necessary for the treatment of my child.

b) I acknowledge that all original records and diagnostic aids are the property of Petit Smiles. Copies may be furnished upon written request based on established policies of the office. There is a small duplication fee.

c) I grant permission to Petit Smiles to reproduce, or use at its sole discretion, these records, x-rays, and photographs for the purpose of teaching, research, or scientific publications.

d) I acknowledge that appointments are scheduled in advance and the time is reserved for my child. To avoid a missed appointment fee, I must cancel at least 24 hours in advance.

I have read and understood the above consent. My questions regarding any of the above items have been answered.

Signature: ..... Print Name: .....
First Last

Relationship to patient: ..... Date: .....
month/day/year

1535 Sunset Drive, Coral Gables, Fl . 33143
tel: 800-895-1570 fax: 800-928-3811
www.petitsmiles.com

PetitSmiles
PEDIATRIC DENTISTRY

Consent for Treatment of Pediatric Patients

Before we begin dental treatment on your child, we are requesting your permission for the following dental procedures which include, but are not limited to, the use of local anesthesia (Xylocaine or Septocaine), nitrous oxide, a comfortable mouth prop (tooth pillow) and the placement of dental restorations and/or appliances as required to return teeth to health and proper function.

The dental appointment presents the young child with many new and unfamiliar experiences. It is completely normal for some children to react to these new experiences by crying. Verbal encouragement using a simple explanation (tell-show-do) and positive reinforcement (a prize for being a good helper) are used first. If these approaches are unsuccessful, it is sometimes necessary for the dentist to speak firmly to the child to gain his/ her attention (voice control). Occasionally, it is also necessary to use some form of physical restraint to protect the child from self injury. The dental environment is full of potential hazards for children; there are sharp objects that must be used near the face and eyes of our young patients during treatment. Most commonly used is a passive arm placed across the child for a short duration.

I have been given the opportunity to discuss the proposed dental treatment and behavior plan with Dr Ruiz. The expected benefits of treatment, the anticipated risks, possible complications and alternatives of treatment have been explained to me. I understand the consequences of non-treatment of my child's dental condition and acknowledgement that no guarantees have been made to me concerning the results of the proposed procedures.

I have read and fully understand the above information on child behavior management and give my informed consent to the pediatric dentist for use of any of these behavior management techniques in the dental treatment of my child. This consent shall remain in full force unless withdrawn in writing by the person who has signed this on behalf of this minor patient.

I understand that photographs and video may be taken of this procedure and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the procedure by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify the pictures.
b. The picture is used only for medical/dental study or research.
c. I agree/do not agree to allow a picture to be on new patient board in the clinic.

Signature: ..... Today's Date: .....
month/day/year

Relationship to patient: .....

Patient's Name: ..... Date of Birth: .....
First Last month/day/year

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