CONSENT FOR PEDIATRIC TREATMENT

I hereby authorize the doctors at Thrive Dental & Orthodontics, along with their staff, to perform treatment on my dependent, who is a minor, on tooth number(s):_____

_____ **Sealant:** Sealants are a flowable plastic placed into the grooves and pits on the biting surface of a tooth to help prevent cavities (decay) on both primary/baby teeth and permanent/adult teeth.

Sealants do not prevent cavities in-between the teeth. Sealants can become loose, chipped, or dislodged and may need to be repaired or replaced. Your child will be evaluated every 6 months to check the status of their sealants.

_____ **Composite Fillings:** Fillings replace tooth structure lost due to cavities (decay), trauma, or fracture. Composite is used to restore the shape and function of the tooth/teeth.

Untreated cavities (decay) can result in an abscessed tooth causing pain and infection. The dentist will remove the cavity and the tooth/teeth will be filled with white filling material. Sensitivity of the treated tooth/teeth can occur to temperatures, biting, and sweets. Additional future treatments may be required.

_____ **Stainless Steel Crown:** A stainless steel crown is a pre-made, silver crown (cap) that covers a primary/baby tooth. It replaces tooth structure lost due to a cavity (decay), trauma, or fracture that is too large for a filling.

If a tooth has a large cavity (decay) or fracture, a filling will not stay in place and can increase the risk of tooth fracture and/or abscess causing pain and infection. The dentist will prepare the tooth/teeth and the SSC will be cemented over the tooth to protect it until the tooth/teeth naturally fall out. The tooth and gum tissue may be sore after treatment. Additional future treatments may be required.

_____ **Pulpotomy:** Pulp (nerve) treatment, or a “baby root canal,” involves the removal of a portion of the nerve inside a primary/baby tooth, and placement of a medicated material.

When cavities (decay), trauma, or fracture affect the nerve inside the tooth, the infected tissue must be removed. After pulp treatment, a stainless steel crown will be placed. The tooth and gum tissue may be sore after treatment. Additional future treatments may be required.

_____ **Extraction:** An extraction is the removal of a primary/baby or permanent/adult tooth/teeth.

An extraction may be necessary due to severe cavities (decay), abscess/infection, or orthodontic treatment recommendations. After placement of anesthetic to “numb” the tooth and minimize pain, the patient will still feel pressure. Although not painful, the pressure sensation is often uncomfortable to some children. A space maintainer may be recommended after extractions.

_____ **Space Maintainer:** A space maintainer minimizes the shifting of teeth into the space created from an extraction of a primary/baby tooth. If the space is not maintained, it can cause or increase crowding of the permanent teeth.

The type and location of the space maintainer will be determined by the dentist. Following the cementation of a space maintainer, your child will be evaluated every 6 months to ensure its fit and possible removal. If the teeth and gums are not properly cleaned, cavities and sore gums can easily develop. Additional, future visits to re-cement or possibly remake the space maintainer if damaged or lost may be required.

I understand that my child's diet and oral hygiene will influence the longevity of dental treatment. If new or recurrent cavities (decay) form around sealants, fillings, SSCs, and space maintainers, they may need replacement or more extensive treatment.

I understand that if my child was numbed for treatment, I must watch my child carefully for the full duration of the local anesthetic to ensure they do not bite, pinch, scratch, or otherwise, injure themselves where they are anesthetized. This can include lips, cheeks, gums, and tongue next to where dental treatment was performed.

I understand that if my child's behavior prevents the treating dentist from completing today's treatment, either due to age, fear, or non-cooperation, a referral will be given to complete all remaining dental treatment with a board certified pediatric dentist.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of today's treatment, and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any. No guarantees or promises have been made to me concerning the results of treatment to be rendered. The fees for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize the doctors at Thrive Dental & Orthodontics to render any treatment necessary or advisable to my dependent's dental conditions.

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Patient's Name (please print)

_____ _____

Signature of Patient, Legal Guardian, or Authorized Representative Date

_____ _____

Witness Signature Date