Crabapple
Pediatric Dentistry & Orthodontics

# CONSENT FOR PEDIATRIC DENTAL TREATMENT

**Prevailing Medical/Dental Practice Law Requires That We Ask You To Read The Following. We Apologize In Advance For The Impersonal Nature Of This Form.**

1. **I am the parent or guardian and have legal authority to give consent for medical/dental treatment for him/her.**
2. **I give my consent to Crabapple Pediatric Dentistry and Orthodontics doctors/personnel as he/she may designate to render dental and/or any emergency medical procedures deemed necessary or advisable.**
3. **I give my consent to use local anesthetics, nitrous oxide (laughing gas), and other medicines or materials as necessary, and to radiographs and photographs as needed for diagnosis, patient records and insurance requirements or documentation.**
4. **The aspects of dental treatment will be explained to me to my satisfaction and a copy of the treatment plan will be given to me per my request. The procedures, the benefits and disadvantages of treatment, any alternatives, possible side effects and complications, as well as the prognosis if no treatment is provided will also be explained.**
5. **I understand that during the course of treatment my child may become uncooperative and restraint may be necessary (e.g. hand holding) to safely complete treatment. I also understand that I will be informed during and after treatment if this is necessary.**
6. **I understand that, although good results are expected, the possibility and nature of complications cannot always be accurately anticipated. Therefore, there is no guarantee expressed or implied either to the result of the treatment or as to the cure.**
7. **I have been given an opportunity to ask any questions I might have.**
8. **This consent will be in force indefinitely until rescinded by me.**
9. **I have read and I understand this consent form.**

# PEDIATRIC DENTAL OFFICE POLICIES REGARDING

## APPOINTMENTS:

**I understand that:**

- **I must present my insurance card at EVERY appointment.**
- **Payment is expected at the end of EACH appointment.**
- **If I arrive more than 10 minutes late for my child's scheduled appointment, the appointment may need to be rescheduled.**
- **A legal guardian must be present and remain in the office while child/children receive treatment.**
- **Changes or cancellations to appointments must be made no less than 48 hours prior to the scheduled appointment. If not, a $50.00 broken appointment fee will be assessed to the patient's account per appointment.**

## FLUORIDE:

**In accordance with the treatment recommendations of the American Academy of Pediatric Dentistry, every child receives a fluoride treatment at each cleaning appointment. It is your responsibility to know if this fee is covered by your insurance at each visit. If its not covered by insurance the fee is $30.**

## DISMISSAL FROM OUR PRACTICE:

**Unfortunately, we must dismiss patients who:**

- **Miss TWO scheduled appointments in one year. A rescheduled appointment due to tardiness is considered a missed appointment.**
- **Fail to schedule and/or keep treatment appointments within 30 days after decay has been detected and treatment has been recommended.**
- **Cannot handle or commit to their financial obligations to this office.**

**If you have any questions regarding these policies, please do not hesitate to ask one of our trained pediatric dental team members. I understand and agree with the above stated policies regarding appointments, fluoride and dismissal procedures. I have also read and signed a copy of Crabapple Pediatrics & Orthodontics "Notice of Privacy Practices".**

**Parent Signature:** _____ **Date:** _____