9815 Main St, Suite 200, Damascus, MD 20872

INFORMED CONSENT FOR PEDIATRIC DENTAL TREATMENT OF:

It is necessary for us as health professionals to obtain your consent for your child's planned dental treatment or oral surgery. Please read the form carefully and let us know if there is anything we can help clarify.

1. I hereby authorize Dr. Naru Baliga and/or her Associate and their hygienists/assistants to perform upon my child the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, analgesia, or radiographs.

In general terms, the dental procedures will include but not limited to:

a) Teeth cleaning, fluoride application, and any necessary X-rays
b) Photograph, film, videotape, record and/or interview (may be used either internally or externally)
c) Applying plastic "sealants" to the grooves of teeth
d) Repairing diseased/ broken/decayed teeth with white fillings or SS crowns or white crowns
e) Treating infected teeth with root canal therapy and/or gum disease
f) Removal of one or more teeth and space maintainer appliances
**I understand that on some occasions treatment is subject to change once in the dental treatment chair. I authorize any necessary changes to be made by Dr. Baliga and/ or her Associates to do what is in the best interest of my child.

2. I have had explained to me by Dr. Naru Baliga and/or her Associate, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from the treatment plan, compared with alternative approaches and/or no treatment.

3. Although their occurrence is extremely remote, some risks are known to be associated with dental procedures. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. Occasionally, a child may also chew/irritate her or her own cheek, lip, or tongue while numb. It is the responsibility of the parent to closely monitor children who are numb to decrease the risk of such complication.

4. I understand it is the goal of New Smiles Kids Dentistry to accomplish dental treatment by the use of warmth, friendliness, persuasion, humor, charm, gentleness and kindness and understanding. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

5. I understand that should my child become uncooperative during dental procedures, dental treatment cannot be safely provided. At that time, for your child's safety, we will stop treatment at a safe point and talk to you about alternative options.

In general terms, the behavior management techniques during treatment will include:
a. TLC
b. Distraction
c. Tell, Show, Do
d. Positive reinforcement
e. Use of voice control to gain your child's attention
f. Use of active or physical restraint to safely accomplish necessary dental procedures, with your help, the parent, and that of our highly trained dental team

The above behavior management techniques have been explained to me both verbally and in writing. I have had a chance to ask questions. I understand the what, when, how, and why of their use, and the risks/benefits/available alternatives.
5. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient, without disclosing the identity of my child, for diagnostic, scientific, educational or research purposes.

6. I understand that I may revoke the consent to treatment at any time and that no further action based on the consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

7. I confirm that I have read (or it was read to me) and understand the information on the front and back of the form, and that all blanks were filled in, and all inapplicable paragraphs, if any, were stricken before I signed below. The proposed treatment has been explained to me, as have any alternative methods of treatment, and the advantages and disadvantages of each. I am advised that although good results are expected, the possibility and nature of complications cannot always be accurately anticipated. Therefore, there can be no guarantee as to the result of the treatment.