# PEDIATRIC DENTAL CONSENT FOR DENTAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

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.

1. I hereby authorize and direct Dr. Robert Raymond, assisted by other dentists and/or dental auxiliaries of his choice, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-ray) or diagnostic aids.
2. The following are procedures a pediatric dentist may perform. **Any of the following will be explained prior to the specific procedure.** You have the right to refuse consent to a procedure before it is performed. In general terms the dental procedure(s) or operation may include:

    A. Cleaning of the teeth and the application of dental fluoride.
    B. Dental x-rays.
    C. Application of plastic "sealants" to the grooves of the teeth.
    D. Treatment of diseased or injured teeth with dental restorations.
    E. Replacement of missing teeth with dental prosthesis.
    F. Removal (extraction) of one or more teeth.
    G. Treatment of diseased or injured oral tissues (hard/soft).
    H. Treatment of malposed (crooked) teeth or development or growth abnormalities.
    I. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
    J. Use of sedative drugs to control apprehension and/or disruptive behavior.
    K. Use of general anesthesia to accomplish the necessary treatment.
    L. Other

This treatment has been explained to me. Alternative methods of treatment, if any, have also been explained to me as have the advantages and disadvantages of each. I am advised that, though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the results of the treatment or as to cure. I further authorize the doctor to perform other dental services that, in his judgment, are advisable for my child or legal ward, with the exception of (if none so state):

_____

3. Although their occurrences are extremely remote, some risks are known to be associated with dental or oral surgery procedures including anesthesia or sedation. State Law requires us to mention the risks of numbness: Infection, swelling, bleeding, discoloration, scarring, nausea, vomiting, and allergic reactions. I further understand medical complications mat arise requiring hospitalization.
4. I also authorize Dr. Robert Raymond to use photographs, radiographs, or other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

I hereby state that I have read and understand this consent, and that all questions about the procedure or the procedures have been answered in a satisfactory manner, and I understand that I have the right to be provided with answers to questions which may arise during the course of my child's or legal ward's treatment.
I further understand that this consent will remain in effect until such time I choose to terminate it.

Patient's name_____Date:_____Time:_____

Signature of Patient or Guardian:_____

Relationship to Patient:_____Witness:_____
I certify that I explained the above procedures and techniques to the parents or legal guardians before requesting their signature.

_____
Dentist's signature

# HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a friendly version. A more complete text is posted in the office. What this is all about: specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov. We have adopted the following policies:

1. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files maybe stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____date_____do hereby Consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature:_____