Dental Consent and Authorization Form

Dental Consent to Treatment

I hereby grant permission for Great Mines Health Center (GMHC) and/or other affiliated dentists or dental auxiliaries of GMHC to perform those procedures and treatments deemed necessary or advisable for complete care of a dependent for whom I am legally responsible. Unforeseen circumstances or conditions may require a departure from the original proposed treatment plan. I authorize any Great Mines Health Center licensed provider, and/or dental auxiliary, to perform comprehensive dental care to include but not limited to the following:

Procedures: dental Radiographs (x-rays), examinations and diagnosis, dental prophylaxis (cleaning), and topical fluoride, application of sealants to the grooves of the teeth, Use of local anesthesia to numb the teeth and tissues, treatment of diseased or injured teeth with dental restorations (fillings): Composite Resin (white fillings), Amalgam (silver fillings), Stainless Steel Crowns, Pulpal Treatment (nerve involvement), treatment of injured or infected pulps (nerve) of teeth, removal (Extraction of teeth), Primary (Baby), Permanent (Adult), replacement of missing teeth with dental prosthesis, treatment of diseased or injured oral tissues (hard and soft), treatment of malposed (crooked) teeth and/or oral developmental and growth abnormalities.). Nitrous Oxide/Oxygen (commonly called laughing gas) to alleviate anxiety during dental treatment.

Safety - Physical restraint or restraining devices will be used only when necessary to safely accomplish the dental procedure(s). Physical restraint will consist of: Holding hands and head still, and/or Blanket Wrap and/or Pillow Case (arms).

List any exception:_____

Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated; therefore, there can be no guarantee expressed or implied either as to the result of the treatment or as to the cure.

Risk - Although occurrence are not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complication associated with pediatric dental treatment is nausea following anesthesia. Less common complications to local anesthetics are: prolonged of permanent numbness of the cheeks, lips, tongue, or gums, allergic reaction, rapid heart rate, or a reaction with other drugs they are taking. There is a possibility that the patient might bite the inside of the mouth or tongue before the local anesthetic wears off. The child must be instructed not to do so. Less common treatment complications are: numbness, infection, swelling, prolonged bleeding, tooth discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form or extracted tooth or gauze packing, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root, which may require additional surgery for its removal. I further understand and accept that complications may occur and may require additional medical, dental or surgical treatment, and hospitalization. After treatment, your child may experience pain and swelling. Although child is usually alert and awake upon leaving the office, if Nitrous oxide (laughing gas) is administered, there are rare instances of lingering sedation.

If I do not remain in the dental office while my child is receiving treatment, I am leaving the treatment up to the doctor's judgment and experience, understanding that other treatment may be necessary. If contact with me is not successful, the doctor and GMHC staff have my permission to perform procedures and treatment deemed necessary or advisable.

I have read and understand this informed consent form. I have had an opportunity to ask any questions I might have, and all of my questions, about the procedures, have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I understand that during the course of the planned procedure(s), unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those contemplated. I understand that I am free to withdraw my consent to treatment, with written notice, at any time and that this consent will remain in effect until I choose to terminate it.

Patient's Name: _____Date of Birth_____

Signature of Parent or Guardian: _____

Name and Relationship to Patient: _____Date_____

Office Staff Only_____

Witness:_____ Date_____

I certify that I explained the above procedures to the parent or legal guardian before requesting his or her signature.

Revised 8/6/19

Great Mines Health Center

Caries Risk Assessment Form (0-6)

Patient Name:	
Birthdate:	Date:
Age:	Initials:

The following questions were developed by the American Dental Association to help evaluate the risk that your child has for the development of tooth decay. Accurate answers will help us provide the proper dental treatment for your child.

Contributing conditions to caries development or prevention (Parent section) **Please circle the answers that best applies to your child**				
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	YES	NO	
II.	**Sugary Foods or Drinks** (including juice, carbonated soft drinks, energy drinks, etc…)	Primarily at mealtimes	Frequent or prolonged exposure between meals	Bottle or sippy cup with anything other than water at bedtime
How many times a day does your child have snacks or sugary drinks between meals? 1, 2, 3, more than 3 times a day				
III.	**Eligible for Government Programs** (WIC, Head Start, Medicaid or SCHIP)	NO		YES
IV.	**Caries or cavity Experience of Mother, Caregiver and/or other Siblings**	No cavities in the last 24 months	Cavities in the last 7 to 23 months	Cavities in the last 6 months
V.	**Dental Home:** regularly sees a dentist for treatment	YES	NO	
VI.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers	NO		YES

Office use only below this line

Clinical Conditions (Circle all that apply)				
I.	Visual or radiographic evidence of restorations, cavitated or non-cavitated carious lesions	No new caries or restorations within 24 months		Carious lesions or restorations in the last 24 months
II.	Missing teeth due to caries	No		Yes
III.	Visible plaque	No	Yes	
IV.	Dental / Orthodontic Appliances present	No	Yes	
V.	Salivary Flow	Visually adequate		Visually inadequate

Overall assessment of dental caries risk: **Low** **Moderate** **High**

Med History Update 2014(Copy)(Updated for Alerts 2018)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you drink alcohol?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____