TopSmileClinic
Dental • Cosmetic

Smile with confidence

Patient Consent to Treatment

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

(Initials) _____

(Please Print Name) _____ _____

Pedodontics (Child Dentistry)

I understand that the following procedures are routinely used at Mascot Dental Centre, as well as being accepted procedures in the dental profession.

A. POSITIVE REINFORCEMENT – Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
B. VOICE CONTROL – The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT – Restraining the child's disruptive movements by holding down their hands, upper body, head and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board").
D. NITROUS OXIDE AND/OR ORAL SEDATION – Nitrous oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent/guardian must understand that the child should **not** eat or drink for a period of four (4) hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.
I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.
I understand the need to return to the office within three (3) months following nerve treatment of a "baby tooth" for evaluation and the possibility of it then needing an extraction.

(Initials)_____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

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I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT MASCOT DENTAL CENTRE PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOUR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DIABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

SIGNATURE: _____ DATE: _____

PATIENT/PARENT/GUARDIAN

Please feel free to contact your Dentist at any stage if you have questions.

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