Smiles in Bloom Pediatric Dentistry
137 Prospect Hill Rd. East Windsor, CT 06088
P: 860-254-5840
F: 860-254-5830

Consent for Treatment

Patient Name: _____ Date: _____

Dental Treatment: I authorize Smiles in Bloom Pediatric Dentistry team (treating doctor and/or dental auxiliaries of their choice) to perform the recommended treatment as discussed to restore my child's oral health. I understand that there may be risks involved in any treatment and hereby acknowledge that these risks and alternatives have been explained to me and that I will have an opportunity to ask questions regarding the risks, benefits, and alternatives of all treatment options, including no treatment. I also understand that dentistry is not an exact science and treatment recommendations may change if there is a change in the status of my child's oral health. I understand that the following list of treatments as described may be included in my child's plan. I understand that these brief descriptions of possible treatment, rationale, and expected post-operative care needs are not all inclusive and that further discussion with the dentist is needed if other questions exist.

Please initial each box after you have had the opportunity to read the description. All treatment will be discussed in further detail before any treatment is rendered.

☐ **Nitrous oxide analgesia**: Also known as laughing gas, it is a colorless/odorless gas that is inhaled to assist with relaxation and comfort for dental care. Its use has limitations and absolute success cannot be guaranteed.

☐ **Sealant**: A preventive service to help reduce risk of future tooth decay and is applied to the deep pits and grooves of a permanent tooth.

☐ **Filling**: Tooth colored fillings are used to eliminate smaller areas of decay or small fractures/defects on teeth. We are an amalgam (silver fillings) free practice.

☐ **Pulp therapy**: A pulpotomy or pulpectomy treatment is required to reduce the need for premature tooth loss when tooth decay or fracture/defect extends towards the tooth nerve/blood supply.

☐ **Stainless steel crown:** A chrome-steel cap that fits over the tooth. Larger areas of tooth decay or tooth defect/fracture require stainless steel crown for best expected outcome.

☐ **Dental extraction:** Removal of the tooth, typically due to extensive decay, infection, to facilitate orthodontic therapy, or due to oral trauma.

☐ **Interim Therapeutic Restoration:** Protective covering (temporary filling) that is not considered permanent and is intended to slow the process of tooth decay.

☐ **Space maintainer**: A fixed device that is cemented to an adjacent tooth that prevents loss of space in the event of premature primary tooth loss.

If behavior does not allow for safe delivery of care in a psychologically protective manner, the treating doctor may abort treatment and develop an alternative plan to safely accomplish treatment on an alternative day. I understand that if I become uncomfortable proceeding with treatment at ANY time, I must inform the team. I understand that it is best to discuss concerns prior to treatment starting, as some treatment must reach some level of completion once initiated.

Parent/ Legal Guardian's signature: _____ Date: _____
Relationship to patient: _____
Printed Name: _____