HIGH HOUSE PEDIATRIC DENTISTRY **RAYMOND J TSENG, DDS, PhD**
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DENTAL DIAGNOSTIC, PREVENTIVE, & OPERATIVE TREATMENT CONSENT FORM

Patient Name: _____ Date: _____

Please read this form carefully. If you have any questions, please ask our staff members for assistance.

I understand the treatment for children includes efforts to guide their behavior by helping them to understand the treatment in an age-appropriate manner. Behavioral techniques may include praise, explanations, and demonstration of equipment and procedures using variable voice tone and volume.

- I understand, request, and authorize dental x-rays to be taken as deemed necessary by Dr. Tseng and associate(s) to diagnose dental disease. **Failure to comply with this will result in dismissal from our practice.**
- **No food and/or beverages are allowed in treatment area.** Per federal occupational safety and health administration guidelines, food and/or beverages are not allowed in the treatment area. With all the tooth dust, polishing paste, and water spray flying around, it's possible for food and/or drinks to be contaminated.
- **No cell phone and/or camera usage in the treatment area.** We love to see smiling kids after having a great checkup or after doing a great job during an operative visit. Please feel free to take pictures during checkout or after leaving the clinical area, out of respect for other patients and team members who may be in the area.
- **If you accompany your child, please assume the role of a silent observer.** Your presence is greatly enhanced if you play a passive role. If more than one person is speaking to the child, they may become confused. For the development of a long-term relationship between your child and our dental team, cooperation and trust must be established directly between the doctor/staff and your child. We also ask that siblings that are not being seen to remain in the reception area. If you have very young children, this may require you to remain in the reception area.
- I understand that if the patient becomes uncooperative with movement of the head, arms, and/or legs, dental treatment **CANNOT be safely administered**. In this case, it may be necessary for the assistants to hold the patient's hands, stabilize the head, and /or control leg movements. In certain circumstances, doctor may ask for the help of the parent or guardian.
- I understand that should the patient become uncooperative during dental procedures with excessive body movements, **treatment will be STOPPED.** Unfinished dental treatment will be temporized (treated with a temporary treatment), and alternative approaches to complete treatment will be discussed. The parent/guardian is responsible for the cost of any temporary treatments, as well as any additional treatments needed to complete the treatment plan.
- All information contained in hard copy and electronic patient records, including clinical photographs, **may be used for diagnostic, scientific, education, and/or research purposes.**
- Dr. Ray, associate(s), and staff are here to help. I understand that the use of inappropriate or abusive language is not allowed with other patients, with staff members, and/or with doctor(s) in our office. **Inappropriate behavior/language is grounds for dismissal from our practice immediately.**

Your signature at the bottom indicates your agreement with our consent for pediatric dental treatment in its entirety. I parent/guardian, hereby authorize Dr. Tseng, associate(s), staff, and/or other medical professionals to perform the procedure(s) or treatment(s) indicated below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures that may be required as a life-saving measure.

I give consent to following treatment for my child: (circle all procedures to be completed on the day of the visit)

Diagnostic/Preventive: (includes all oral exams, cleaning, x-rays, fluoride)

Fillings Crowns Sealants Extractions Silver Diamine Nitrous Pulpotomy

Fluoride: (circle this only if performed outside of insurance frequency: **Patient Cost is $ _____**) No Fluoride

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I understand that all copays are due at the time of service.

I confirm that I have read and understand this form OR it was read to me and all blanks were filled for me before I signed below.

Parent/Guardian Signature: _____ Date: _____

Doctor/Staff Signature: _____ Date: _____