ALLISON B. ROSE, DMD
BOARD CERTIFIED

COLLEGEVILLE PEDIATRIC DENTISTRY

PATIENT INFORMED CONSENT

Please read this form carefully and ask about anything you do not understand.

GENERAL VISITS

Each child is a unique individual that may require particular treatment dependent on their age, oral history, and behavior. However, typical biannual dental visits include a general examination, cleaning of the teeth, application of topical fluoride, and annual radiographs (x-rays). You must inform the office at each visit if you do not wish to have fluoride prior to the beginning of your child's visit.

OPERATIVE

If your child should need additional treatment, the doctor will create a unique treatment plan. This treatment plan is to be used as a guideline and is continually influenced by a child's diet, home health care, and the timeframe between work's initiation and completion. All treatment options, alternatives, advantages, and disadvantages are explained to the attending parent(s)/ guardian(s) at the initial exam, and discussion is available at every appointment.

INFORMED CONSENT

● I understand the risks associated with dental treatment, such as numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions, infection, and hospitalization.

● I understand good results are expected with dental treatment but that it is not possible to guarantee oral health.

● I understand the benefits, risks, and side effects of dental treatment, and the possible consequences of denying treatment. I understand it is my right to accept or deny any treatment prior to the beginning of my child's visit.

● I understand I am to honor my appointment date and time. Appointments require 24-hours notice to cancel and a penalty charge of $50.00 per patient will be incurred after the 1st offense. If I am more than 15 minutes late to an appointment, the appointment may be cancelled.

● I understand I am to remain within the dental office while my child is being treated.

● I understand the office recommends treatment according to my child's health and not by what is covered by my insurance. It is my responsibility to understand all aspects of my dental benefits including eligibility, terms, conditions, limitations, coordination of benefits, and other plan provisions at the time services are rendered. I understand the office will submit my insurance claims as a courtesy but does not guarantee insurance payment, and that any procedure not covered for any reason is my financial responsibility.

● Should unforeseen conditions arise, such as a change in planned treatment, I understand that the doctor will complete comprehensive care based on their professional judgment. Additional procedures which are deemed necessary will be performed and payment for these procedures are my financial responsibility.

PARENT/ GUARDIAN (print) _____

PARENT/ GUARDIAN (signature) _____ **DATE** _____/_____/_____

PATIENT(S) NAME (print) _____