

# BabyTeeth Children's Dentistry

## CONSENT FOR DENTAL TREATMENT UNDER SEDATION

I, \_\_\_\_\_, as the legally responsible parent/guardian of \_\_\_\_\_, give my consent to the use of local anesthetics, sedative drugs, and/or physical restraint that Dr.(s)

\_\_\_\_\_ may deem necessary or advisable so as to enable them to render necessary dental treatment as indicated on the child's examination chart, as previously explained to me, and any other procedure deemed necessary or advisable as an adjunct to the

planned treatment for \_\_\_\_\_, with the exception of (if none,

so state): \_\_\_\_\_. I have been informed and understand that occasionally there are complications of the treatment, drugs, or anesthetic agents, including but not limited to amnesia, numbness, infection, swelling, bleeding, nausea, vomiting, and allergic reactions. I further understand and accept that complications may require hospitalization.

Dr.(s) \_\_\_\_\_ has/have discussed these complications with me, to my satisfaction.

I understand that the sedation may prove partially or completely ineffective in managing my child. In such an instance, the planned treatment may not be possible or may require several appointments using this sedation technique to complete the necessary dental work, and/or an alternative treatment may be instituted.

I acknowledge the receipt of and understand the preoperative and postoperative instructions. The treatment and sedation and/or anesthesia procedures have been explained to me, to my satisfaction, along with possible alternative methods and their advantages and disadvantages, risks, and consequences, and probable effectiveness of each as well as the prognosis if no treatment is provided.

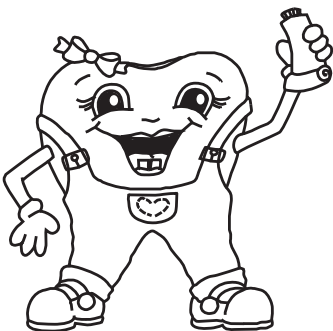
I have read this consent and understand, to my satisfaction, the procedures to be performed and accept the possible risks.

Name of Patient: \_\_\_\_\_

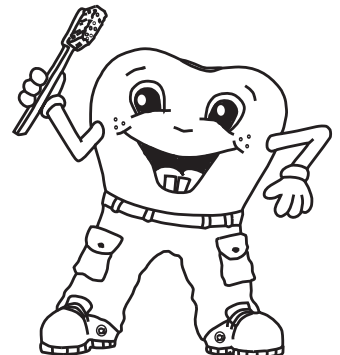
Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I explained the above procedures to the parent/guardian before requesting their signature.

Dentist Performing Procedure: \_\_\_\_\_ Date: \_\_\_\_\_



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## INSTRUCTIONS REGARDING TREATMENT UNDER ORAL SEDATION

As has been discussed, your child will be receiving a sedative medication prior to his/her dental care. The purpose of this sedative is to help make it easier for your child to receive dental care. The sedative is not intended to put your child to sleep, rather it should help your child to be calm and relaxed, allowing us to provide the best quality dental care under the safest conditions.

The sedative will be given to your child by his/her dentist before the dental treatment is begun. Therefore, it is important that you arrive at the office promptly. After the medication has been given it is not uncommon for your child to appear slightly agitated as the medication begin to take effect. He or she will calm down as more drug is absorbed and this should not be cause for alarm. The sedative may make your child dizzy and clumsy and he/she should not be allowed to walk or run around unassisted. It is best if your child is kept sitting on your lap, or sitting on a chair next to you. This dizziness and sleepiness may last for several hours after the appointment, and a close watch should be kept on your child to make sure that he/she does not hurt himself/herself. If your child falls asleep, please make sure that he/she sleeps on his/her stomach or side, **NOT ON HIS/HER BACK**. For his/her safety, your child may be placed in a papoose board during the treatment. Since the effects of sedation may last a few hours after completion of the dental treatment it is important that your child be allowed to rest under the supervision of an adult for the remainder of the day. Your child should avoid any physical activities for the remainder of the day.

A \$ \_\_\_\_\_, non-refundable, deposit is required prior to scheduling the sedation appointment. This deposit will be applied to the treatments rendered under sedation. A minimum of 5 days advance notice is required for any cancellations and/or rescheduling of sedation appointment; otherwise a fee of \$350 or 50% of the amount of the treatment plan estimate, which ever is greater, may be charged.

We strongly suggest that a second adult come with you to assist during transportation following the treatment. Please follow these instructions **PRIOR** to the sedation appointment:

- If possible, prior to the appointment try to reassure your child that he/she will be treated in a friendly, and caring environment. Try to "paint a POSITIVE mental image."
- If your child has an elevated temperature, is sick, or has trouble breathing through his/her nose, please call us as soon as possible so that we may reschedule the appointment.
- Unless told otherwise by the anesthesiologist, don't give your child anything to eat or drink for **AT LEAST 6 hours** before the appointment.
- Arrive to the appointment on time! Failure to arrive at the office promptly, may necessitate rescheduling the appointment and a fee of \$350 or 50% of the amount of the treatment plan estimate, which ever is greater, may be charged.
- Take the child to the restroom when you arrive at our office, prior to the administration of the sedation.

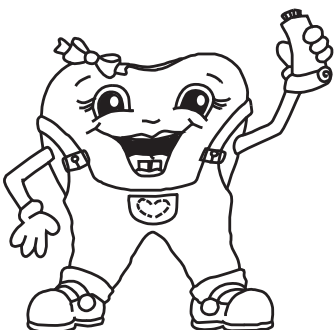
If you have any questions, please feel free to ask us. It is in everyone's best interest that the above instructions are followed; we look forward to treating your child in the safest, most comfortable manner possible.

I have read and understand this letter and have had an opportunity to ask any related questions.

Name of Patient: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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