DENTISTRY FOR CHILDREN
Michael and Chan Smiles, Ltd.
850 I Street • Sparks, Nevada 89431
775.358.5330

Dear Parent or Guardian,

We are striving to make your child's visit a positive experience with an end result of minimum stress and a willingness to return to our office. The following are choices or ways for your child to receiv dental treatment.

1. NO ANESTHESIA
2. LOCAL ANESTHESIA ONLY
3. NITROUS OXIDE-OXYGEN ANALGESIA ONLY
4. NITROUS OXIDE-OXYGEN ANALGESIA COMBINED WITH A LOCAL ANESTHESIA
5. ORAL PRE-MEDICATION (A MIXTURE OF CHEMICAL AGENTS THAT REDUCE PAIN. AWARENESS AND APPREHENSION) COMBINED WITH A LOCAL ANESTHESIA AND NITROUS OXIDE-OXYGEN ANALGESIA. (ADDITIONAL $260.00).

5a. (OPTIONAL) NITROUS OXIDE-OXYGEN ANALGESIA WITH LOCAL ANESTHETIC WHILE TRAINED ASSISTANT HOLDS CHILD FOR DENTAL PROCEDURES. THIS IS AVAILABLE FOR CHILDREN UNDER WEIGHT (LESS THAN 35 POUNDS) AND IN EXCELLENT HEALTH.
AMOUNT OF COMPLETED DENTAL TREATMENT EACH VISIT IS JUDGED BY HOW WELL THE PATIENT TOLERATES THIS PROCEDURE.

6. GENERAL ANESTHESIA PERFORMED AT A SURGICAL CENTER OR HOSPITAL BY AN ANESTHESIOLOGIST.

6a. IN ADDITION TO OUR DENTAL FEES YOU WILL BE RESPONSIBLE FOR: (1) A SPECIAL HOSPITAL SET-UP FEE, (2) HOSPITAL OPERATING ROOM FEE-ESTIMATION $2,500.00, (3) ANESTHESIOLOGIST FEE-ESTIMATION $800.00, (4) PRE-SURGICAL PHYSICAL AND BLOOD TESTS FEE-ESTIMATION $100.00

The above choices will be discussed and an arrangement will be made based on your knowledge of your child, and our experience. If one choice of treatment does not work to your and my standard, treatment will be stopped and another choice will be evaluated to our mutual agreement. It may be necessary to protect your child during treatment by holding hands and/or legs. In addition, a specially designed apparatus called a "Papoose Board" may be used to hold the child during treatment. Please feel free to ask any questions concerning our approach to managing your child before treatment begins.

JOSEPH Y. CHAN, D.D.S., MARY ANN MICHAEL, D.D.S.

ANESTHESIA CONSENT:

I am aware that local anesthesia causes numbness of the lips, tongue and cheek. I understand that lip tongue and cheek biting are a possibility after treatment using local anesthesia. Special caution must be taken to avoid lip, tongue and cheek biting. I acknowledge that if I follow instructions - the chances of this happening are less. As a result of treatment in mouth, the lips are stretched and are likely to swell. Ice packs ½ hour on and ½ hour off will reduce swelling 3-6 hours. If swelling is still present the next day, please call office with that information.

I understand that occasionally there are complications of treatment, drugs or anesthetic agents; including but, not limited to: Numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, stroke or heart attack, quadriplegia, the loss of function of any organ or limb, or disfiguring scars associated with such procedures. I further understand and accept that complications may require hospitalization and possible life threatening circumstances.

Date: _____ **Parent or Guardian Signature:** _____

PEDIATRIC DENTISTRY INFORMED CONSENT for PATIENT MANAGEMENT TECHNIQUES and ACKNOWLEDGEMENT of RECEIPT of INFORMATION

State Law requires health professionals to provide their prospective patients with information regarding the treatment or procedures they are contemplating. State Law also requires us to obtain your consent for any specific dental treatment, procedures or techniques which might be considered to be of concern to the patient or parent. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives.

Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it.

It is our intent that all professional care delivered in our dental operatories shall be of the best possible quality we can provide for each child. Preventing high quality dental care are: hyperactivity, resistive movements, refusing to open the mouth and keeping it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments.

All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

These are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. TELL-SHOW-DO: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's of dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. POSITIVE REINFORCEMENT: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.
3. VOICE CONTROL: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important that the abrupt or sudden nature of the command.
4. MOUTH PROPS: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
5. PHYSICAL RESTRAINT BY THE DENTIST: The dentist retains the child from movement by holding down the child's head between the dentist's arm and body, or positioning the child firmly in the dental chair.
6. PHYSICAL RESTRAINT BY THE ASSISTANT: The assistant restrains the child from movement by holding the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movement.
7. PAPOOSE BOARDS AND PEDI-WRAPS: These are restraining devices for limiting the disruptive child's movement to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in these devices and placed in a reclined dental chair.
8. SEDATION: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally, by injection or as a gas (nitrous Oxide and Oxygen). The child does not become unconscious. Your child will not be sedated without your being further informed and obtaining your specific consent for such procedure.
9. GENERAL ANESTHESIA: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given general anesthesia without your being further informed and obtaining your specific consent for such procedure.

PEDIATRIC DENTISTRY INFORMED CONSENT for PATIENT \ MANAGEMENT TECHNIQUES and ACKNOWLEDGEMENT of RECEIPT of INFORMATION

The listed pediatric dentistry behavior management techniques have been explained to me. Alternate techniques for treatment, if any, have also been explained to me, as have the advantages and disadvantages of each.

I hereby authorize and direct _____ asssisted by other dentists and/or dental auxiliaries of his/her choice, to utilize the behavior management techniqes listed on the reverse side of this form to assist in the provision of the necessary dental treatment for:

_____, my child (or legal ward): with the exception of: (If none, so state).

_____

I hereby acknowledge that I have read and understand this consent, and that all questions about the behavior management techniques described have been answered in a statisfactory manner, and I further understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent shalll remain in effect until terminated by me.

Date: _____ Time: _____ ○ ○ am/pm File Number: _____

Patient's Name: _____

Signature of Parent or Guardian: _____

Relationship to Patient: _____ Witness: _____

I certify that I explained the above procedures and techniques to the parent or legal guardian before requesting their signature.

_____

JOSEPH Y. CHAN, D.D.S.
MARY ANN MICHAEL, D.D.S.

PARENT IN ROOM WHEN TREATMENT IS OCCURRING

On very special occasions, the parent may be invited into the treatment room.
First, the parent MUST read this policy letter.
Second, the Doctor will review the contents of the letter.
Third, and agreement shall be reached by the parent and the Doctor.

Dear Parent:

We have reviewed and looked at every way possible to deliver treatment to children in the most comfortable and effective way. We have gone from one extreme (of letting all parents in the treatment room) to another (no parents in treatment room). In our search for the best, we found out that certain situations worked. The following are those situations.

1. When the parent "acted" like an invited guest.
2. When the parent was there physically but not involved in treatment or conversation unless asked by Doctor.
3. All questions about treatment were discused before treatment began and any new questions about treatment were discussed after treatment was completed.
4. When number 1, 2, and 3 above were not gone along with by the parent, then the parent was asked to leave and did so.
5. A firm agreement was made between doctor and parent to all the above numbers.

Our search for the best has revealed that the parent in the room distracted the doctor and the patient, that the conversation between parent and child interfered with my ability to perform dental treatment. Here is the basic reason - the emotions of the parent and child are such that they trigger feelings of profound sympathy and treatment cannot progress effectively.

The doctors and staff have plenty of sympathetic emotions when treating children; but, if we were overcome by the emotion, then treatment would not be done.

We appreciate your understanding in this matter.

Best Regards,
JOSEPH Y. CHAN, D.D.S.
MARY ANN MICHAEL, D.D.S.

I agree to all parts of this letter and agree to follow all of the Doctor's rules in order to be in the treatment room for the treatment of my child.

PATIENT NAME (PLEASE PRINT)

Date: Signature:

CONSENT for the USE of SEDATION or GENERAL ANESTHESIA
for
PEDIATRIC DENTAL TREATMENT
and ACKNOWLEDGEMENT of RECEIPT of INFORMATION

State Law requires us to obtain your consent to your child's completed treatment. Please read this form carefully and ask us about anything that you do not understand.

I, _____, as the legally responsible parent/guardian of _____ give my consent to the use of local anesthetics, sedative drugs and/or general anesthesia agents that our doctors may deem necessary or advisable so as to enable them to render necessary dental treatment as indicated on my child's examination chart, as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned treatment, with the exception of: (if none, so state.) _____

It may be necessary to manage your child with commands, such as: "You must not yell.". Please be quiet." and "I need your help". None of these procedures will be done without your permission and we want to discuss all phases of patient management with you.

I understand that State Law also requires health professionals to provide their prospective patients with information regarding the treatment they are considering. I acknowledge receipt of the instructions to parents of pediatric patients who are to receive sedation and/or general anesthesia for dental treatment.
I understand that occasionally there are complications of treatment, drugs or anesthetic agents; including but not limited to: numbness, infection, swelling, bleeding, discoloration, nausea, vomiting allergic reactions, brain damage, stroke or heart attack, quadriplegia, paraplegia, the loss of function of any organ or limb, or disfiguring scars associated with such procedures. I further understand and accept that complications may require hospitalization and may even result in death.

The below signed doctor discussed with me to my satisfaction, these complications. I acknowledge that 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; risk, consequences and probable effectiveness of each as well as the prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.

I hereby state that I have read and understand this consent, and that all questions about the procedure or procedures have been answered in a satisfactory manner.

Date: _____ Patient's Name: _____

Signature of Parent or Guardian: _____

Relationship to Patient: _____

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

_____

JOSEPH Y. CHAN, D.D.S.
MARY ANN MICHAEL, D.D.S.