

Pediatric Dental Center of North Idaho

Informed Consent

I give my consent for Dr. John R Ukich and staff to perform the following procedures on my child:

Please place your initials next to all that you consent to during your child's visit:

Prophylaxis (dental cleaning)

Exam

Radiographs (x-rays) as recommended by the dentist

This office follows the guidelines of the American Dental Association and recommends that bitewing x-rays be taken every year to detect and diagnose decay. A panoramic x-ray is taken every five years.

Fluoride treatment

The American Academy of Pediatric Dentistry recommends fluoride be applied twice per year to help aid in the formation of tooth enamel, to repair early stages of tooth decay, and to help prevent decalcification. For these reasons, please be aware that this will be applied at each cleaning unless otherwise notified.

Sealants as needed for my child. Treatment of teeth through the use of sealants is a preventative measure intended to facilitate the inhibition of dental caries (tooth decay or cavities) in the pits and fissures of the chewing surfaces of the teeth. Sealants do not protect the areas between the teeth, so thorough brushing and flossing is necessary. We will repair or replace sealants at no cost for 3 years if they were originally placed at our office.

I understand that refusal of any of the procedures above could result in an incomplete diagnosis or treatment of my child.

Patient's Name: _____ Date: _____

Signature of parent or Guardian: _____

Relationship to Patient: _____