MEDICAL DENTAL OPTOMETRY

Thank you for choosing HEALS, Inc. as the healthcare provider for your child.

Please complete all sections of this form in full.
Incomplete forms may delay or prevent enrollment.

Demographics

Patient's Name: ____
First *Middle* *Last*

Gender: ☐ M ☐ F Gender Identity: ____________ Date of Birth: ______________ SSN: _____________________

Race/Ethnicity (optional): ☐ African American ☐Caucasian ☐Hispanic ☐ Native American ☐ Asian

Address: ____ City: _______________State: _______Zip Code: _________

Home phone: _____________________________ Attending School: ____

Parent/Legal Guardian's Name(s)____Date of Birth: ____________________

Cell Phone: ____Work Phone: ____________________________________

Email____ Another phone we may contact: ___________________

How did you hear about us? ____

Siblings Name (if any)	Date of Birth	Enrolled at HEALS?	Does this child have Medicaid?
______________________________	______________	☐Yes ☐No	☐Yes ☐No
______________________________	______________	☐Yes ☐No	☐Yes ☐No
______________________________	______________	☐Yes ☐No	☐Yes ☐No

Responsible Party

Name of the responsible party (Parent/Guardian): ____

Social Security #: _______________________ DOB: ________________ Gender: ☐Male ☐Female

Employment Status: ☐ Employed. ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Student

Employer's Name: ______________________________ Hire Date: __/___/______ Telephone: _____________________

Address: ____ Job Position: _________________________________

My child is uninsured: ☐Yes ☐No

My child has Medicaid ☐Yes ☐No If YES, please provide Medicaid number: ________________________

My child has other insurance: ____
(Company Name, i.e., BCBS, All Kids, United)

Insurance Number: _________________________________ Group Number: ______________________________

Insured Person's Name: ______________________________ Relationship to the child: _________________________

Insured's date of Birth: _______________________________ Is Dental Care Included: ☐ Yes ☐No

Write your initials in the box for every service you want your child to receive. Boxes left blank mean you do *not* give consent for that service.

I authorize HEALS staff to perform screenings and provide patient education. Medications may be administered if necessary. I will be informed of visits via the healthcare provider, note, phone call or the preferred method of communication.

Medical Services	Dental Services	Optometry Services	Description
____	____	____	**By initialing I consent** to my child and may receive services at any HEALS Clinic **WITHOUT me** being present.
____	____	____	**By initialing I consent** to my child may receive services at any HEALS Clinic **ONLY with me** being present.

Patient Name: ____ DOB: ___________________________

How would you like to be contacted regarding appointments, treatment, and/or other information concerning your child's healthcare at HEALS? Please check all that apply.

☐Home Phone ☐Work Phone ☐Cell Phone ☐Note sent home ☐Patient Portal ☐Text ☐Email.

Voicemails opt-out: If you prefer that **we do not leave a voicemail** at the number(s) you have given us. **Initial here:** ______

I understand that all the information on my child's health record is confidential. I consent to the HEALS clinic staff to speak with appropriate school personnel concerning my child's school and health records, attendance, academic performance, and other information affecting his/her learning and/or behavior.
_____ **Initial here that you understand**.

I authorize the HEALS clinics to release information regarding treatment to doctors, dentists, and third-party payers (insurance companies) for the purpose of obtaining authorization for services, for billing, and for any reason in accordance with acceptable medical practice pursuant to the law. I authorize payments to be made directly to the provider of services.
_____ **Initial here that you understand**.

I understand that it is my/our (parent/guardians') responsibility to provide HEALS with copies and proof of all updated court documents regarding custody.
_____ **Initial here that you understand**.

Audio and video recordings are not allowed. Such recordings interfere with medical and dental treatments and the privacy of our staff and patients.
_____ **Initial here that you understand**.

HEALS No-Show Policy: I understand that if I miss two (2) appointments without notice, my account will be placed on probation. If I miss three (3) appointments, my child may be dismissed from HEALS practice.
_____ **Initial here that you understand**.

HEALS No-Show for Multiple Children Policy: I understand that if I fail to bring my multiple children for their same-day appointment, I will not be able to schedule their next appointments to occur on the same day. The above no-show policy also applies. Only two kids per day may be scheduled at a time.
______ **Initial here that you understand.**

HEALS Late Arrival Policy: If I arrive 10 minutes or later for my scheduled appointment, HEALS has the right to reschedule my child's appointment.
_____ **Initial here that you understand**.

HEALS Cancellation Policy: I understand that **all cancellations must be made at least 24 hours before the scheduled appointment**. If I cancel with less than 24 hours' notice, it will count as **half (½) of a no-show**. If I reach **three (3) no-shows**, my child **may be dismissed** from the HEALS practice.
_____ **Initial here that you understand.**

Name of the parent or guardian filling this Enrollment Form: ____
SIGN HERE: ____
Relationship to child: _______________________________________ Date: ______________________________

HEALS Patient Portal

Get secure and easy access to your medical records and the HEALS professional staff.

Through the Patient Portal, you can:

- View your lab results.
- Send messages to the HEALS staff
- View your medical information such as medication lists, problem lists, allergies, and immunization records.
- Receive appointment reminders and confirm appointments.

Important: The Patient Portal is **not for emergencies.**

- If you have a medical emergency, **call 911** or **go to the nearest emergency room** right away.
- Messages sent through the portal are only read during normal clinic hours.

To Get Started: Ask for your login information on your next office visit.

After-Hours Notice: If you need medical assistance outside of business hours, call 256-428-7560 to connect to our on-call service. Dial 911 for emergencies.

MEDICAL HISTORY

Please complete all sections of this form in full.

Patient's Name: ____
First *Middle Initial* *Last*

Date of Birth: ______________________(*MM/DD/YYYY*)

Primary Care Doctor or Nurse Practitioner (assigned by insurance or the doctor your child sees when sick):

Name of the child's Physician: ________________________ Phone: ________________________

Name of child's Dentist: ___________________________ Phone: ________________________

Name of the Eye Doctor: ___________________________ Phone: ________________________

Does your child have allergies (bee stings, foods, medicines, etc.)? ☐Yes ☐No

If yes, please list:

Allergy	1st Onset	Reaction (Itching, Swelling, Hives, Anaphylactic, etc.)

Is your child taking any daily medications? ☐Yes ☐No

If yes, please list:

Name	Dosage	Route Taken (Orally, Injected, Etc.)	Frequency

Is your child allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex

☐Sulfa Drugs ☐ Other, please explain______________________________________

Is your child currently being treated for any condition (s) or illness (es)? ☐Yes ☐No

Which illness: ________________________When did it start: ____________________________

Was your child born prematurely? ☐Yes ☐No

If yes, please explain: ____

Has your child ever been in the hospital overnight or longer: ☐Yes ☐No

Please explain when and why: ____

Has your child ever had surgery? ☐Yes ☐No

Please explain: ____

Has your child ever been given a general OR local anesthetic? ☐Yes ☐No

Please explain: ____

Has a physician or dentist ever suggested that the patient take **antibiotics** before seeing the dentist? ☐Yes ☐No

Please explain why and provide the name of the doctor making that recommendation:

Why: ____

Doctor's name: ____________________________Phone: ______________________

Does your child have any genetic (inherited) conditions? ☐Yes ☐No

Please explain: ____

Do you have any concerns about your child's physical health? ☐Yes ☐No

Please explain: ____

Patient Name: ____ DOB: ___________________________

Has your child ever had any of the following illnesses or conditions?

Disease or Disorder	Yes	Disease or Disorder	Yes	Disease or Disorder	Yes
ADHD	☐	Easily Winded	☐	Liver Disease	☐
AIDS/HIV	☐	Emphysema	☐	Low Blood Pressure	☐
Anaphylaxis	☐	Emotional Problems	☐	Lung Disease	☐
Anemia	☐	Epilepsy/Seizures	☐	Jaw Pain	☐
Angina	☐	Excessive Bleeding	☐	Parathyroid Disease	☐
Anxiety	☐	Excessive Thirst	☐	Psychiatric Care	☐
Arthritis	☐	Fainting Spells	☐	Radiation Treatments	☐
Artificial Heart Valve	☐	Frequent Cough	☐	Recent Weight Loss	☐
Artificial Joint	☐	Frequent Ear Infections	☐	Renal Dialysis	☐
Asthma	☐	Frequent Eye Infections	☐	Rheumatic Fever	☐
Autism	☐	Frequent Headaches	☐	Rheumatism	☐
Bladder Problems	☐	Genital Herpes	☐	Scarlet Fever	☐
Blood Disease	☐	Glaucoma	☐	Sickle Cell Disease	☐
Blood Transfusion	☐	Growth Problems	☐	Sinusitis	☐
Breathing Problems	☐	Hay Fever	☐	Spina Bifida	☐
Bruise Easily	☐	Hearing Problems	☐	Stomach/Intestinal Disease	☐
Cancer	☐	Heart Attack	☐	Stroke	☐
Cerebral Palsy	☐	Heart Conditions	☐	Swelling of Limb	☐
Chemotherapy	☐	Hemophilia	☐	Thyroid Disease	☐
Chest Pains	☐	Hepatitis A, B, or C	☐	Tonsillitis	☐
Cold Sores	☐	Herpes/Shingles	☐	Tuberculosis	☐
Congenital Heart Disorder	☐	High Blood Pressure	☐	Tumors or Growths	☐
Convulsions	☐	High Cholesterol	☐	Ulcers	☐
Cortisone Medication	☐	Hives or Rash	☐	Venereal Diseases	☐
Developmental Issues	☐	Hypoglycemia	☐	Yellow Jaundice	☐
Depression	☐	Irregular Heartbeat	☐	Other (please specify):	
Diabetes	☐	Kidney Problems	☐	______________________________	
Drug Addiction	☐	Leukemia	☐	______________________________	

Check here if none of the above ☐

Please provide the dates of Diagnosis and Explanations if you answer "YES" to any of the conditions above.

____

Has your child had any serious illnesses that are not listed above? ☐Yes ☐No

Please explain: ____

Do you have any concerns about your child's emotional health? ☐Yes ☐No

Please explain: ____

How would you describe your child's eating habits? ____

How often does your child drink: Sodas: ___/week Juices: ___/ week Energy Drinks: ___/week

How often does your child eat: Candies: ___/week Fruits: ___/week Vegetables: ___/week Meats: ___/week

Is your child up to date with immunizations related to patient hood diseases (tetanus, measles, mumps, etc.)?

☐ Yes ☐ No

If of the appropriate age, what is the patient's Human Papillomavirus/HPV immunization status?

☐ Immunized ☐ Not Immunized

SIGN HERE: _________________________ Relationship to child: ____________________ Date: ________________

Patient Name: ____ DOB: ____________

heals
Health Establishments At Local Schools
Part of the Solution

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I acknowledge that a copy of the HEALS, Inc. Notice of Privacy Practices has been made available to me. Regarding the Notice, I also acknowledge that I have been given the opportunity to ask questions about the Notice and its content. I understand that the most up-to-date version of the Notice will be posted, and copies will be available at any time. The full text detailing our privacy practices is available for your review. We encourage you to read it and ask any questions you may have about our privacy practices.

☐ **I have read and understand the *Notice of Privacy Practices*.**

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: _____________________________________

Relationship to Child: __________________________ Date: _____________________

Signature: ________________________________ Date: __________________

This section is designated only if the patient is over 16 years old.

HEALS IMMUNIZATION SCHEDULE

It is the policy of all HEALS physicians that your child/children receive all immunizations required by the American Academy of Pediatrics. This is a non-negotiable policy for all HEALS physicians. It is our policy that all HEALS patients keep all scheduled well-child checkup appointments yearly until they are eighteen years old.

Newborn	Newborn Screen	12 Months	MMR, Varicella, Pneumococcal Hepatitis A*
2 Months	DTaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus*	15 Months	DTaP, HIB
4 Months	DTaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus*	18 Months	Hepatitis A*
6 Months	DTaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus*	4-Year	DTaP, MMR, Varicella, IPV
9 Months	PPD	11-Years & up	HPV*, Tdap, Meningococcal*

The following immunizations are not *required* but are recommended by the physicians at HEALS Pediatrics:

*Rotavirus
*Hepatitis A
*Meningococcal
*HPV

If you miss three consecutively scheduled well-child checkup appointments, refuse to comply with the required immunizations or excessively abuse scheduled appointments; your child/children will be considered for dismissal from HEALS.

I acknowledge receipt of the immunization policy of HEALS Pediatrics, and by registering my child as a patient of HEALS, I agree to comply with the required immunizations.

_____ With my initials I acknowledge that I have read and understand the *HEALS IMMUNIZATION SCHEDULE*.

Patient Name: ____ DOB: ____________

Authorization to Share Health Information.

If my child is sick or hurt and receives healthcare at a HEALS Clinic, **I give permission for HEALS to share detailed health information with the following persons**. They may also receive information about appointments, treatments and/or other information about healthcare provided to my child at HEALS.

Name	Relation to Child	Phone Number	Leave Message (circle one)
________________________	________________	__________________	Yes / No
________________________	________________	__________________	Yes / No
________________________	________________	__________________	Yes / No

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: ____________________________________

Relationship to Child: _________________________ Date: ____________________

This section must be completed by patients who are 16 years of age or older.

Name of Patient over 16 years of age: ____

Signature: _______________________________ Date: ______________________
Patient over 16 years of age

Phone Number: ____________________ Email: __________________________________

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY RELEASE A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORDS

HEALS, Inc.
Health Establishments at Local Schools

515 Sparkman Dr. NW
Huntsville, AL. 35816

Phone: 256-428-7560
Fax: 256-428-7561

Full Name of Patient: ____

Patient's Birth Date: ____________________ Chart# ______________________

Please provide the information about the Medical Office or Physician to whom we must request the records:

Physician's name/Practice name: ____

Phone number/Fax: ____

Address: ____

INFORMATION TO BE RELEASED (X) ☐ Medical Record ☐ Psychiatric Records

**If only a portion of the medical record or Psychiatric record is required, please specify. **

☐ Discharge Summary ☐ Emergency Room ☐ Laboratory Results
☐ History & Physical ☐ X-Ray Report ☐ Immunization Records
☐ Orders ☐ Operative Reports ☐ Nurses' Notes
☐ Radiology Film/Imaging ☐ Progress Notes ☐ Entire Record
☐Other (Specify) ____

Information is requested by: ____________________________, Clinic Coordinator at the HEALS Clinic. This record is requested to be released to:

HEALS, Inc.
____
Phone: 256-428-7560
Fax: 256-428-7561

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):

☐ Continued Medical Care ☐Insurance purposes ☐Other

The authorization must be signed and dated and may be revoked by notifying HEALS, Inc. in writing at any time except to the extent that action has been taken prior to revocation. This consent will expire 120 days after the date below or sooner by my choice., in which case this consent will expire on this date or event: ____________________________________

Name of the Parent/Guardian: ____

Signature: ____ Date: ________________________
Parent or Legally Authorized Representative

Relationship to the Patient: ____________________ Phone Number: ____________________

Sliding Fee Scale Application

All patients must provide complete proof of income to be considered for discounts. Failure to do so will result in full (100%) responsibility for all service costs. This information is used **ONLY at HEALS** Clinics, and we will not share your personal information.

Patient's Name:		Date of Birth:	Date:	
Social Security Number:		Age:	Male	Female
Is the patient a Full-Time Student? ☐Yes ☐No	School Name:		Grade	Teacher
Household Income #1 Name:		Household Income #1 Social Security #:		
Home #:	Work #:	Cell #:		
Current Address:	Street	City	State	Zip
County:		How long have you been living here?		
Parent/Guardian Employer:		Hire Date: (month/day/year)		
If unemployed – last date worked (month/day/year)		Reason:		
Household Income #2 Name:		Parent/Guardian #2's Social Security #:		
Home #:	Work #:	Cell #:		
Current Address:	Street	City	State	Zip
County:		How long have you been living here?		
Employer:		Hire Date: (month/day/year)		
If unemployed – last date worked (month/day/year)		Reason:		
Are you Renting? ☐Yes ☐ No	Buying ☐Yes ☐ No	Do you Own ☐Yes ☐ No	Living with and/or supported by someone? ☐Yes ☐ No	Who?
Number of dependents relaying on your income:		Relation to you?		
List the ages of **YOUR** children still living in the household:				
Have you ever applied for SSI/Social Security Disability?		Date of last application:		

Information to Connect You with Resources

Please check all that apply:

Homeless: ☐Yes ☐No **Public Housing** ☐Yes ☐No

Worker Status: ☐Migrant ☐Seasonal ☐Not Migrant/Seasonal ☐Refuse to answer.

Disabled: ☐Yes ☐No **Military Discharge:** ☐Yes, **Discharge Date**_______________ ☐No

Refugee Status ☐Yes ☐No **Country of Origin:** ________________________________

Patient's Name ____ DOB: ___________________________

MONTHLY INCOME & MONTHLY EXPENSES

This information is for HEALS Clinics ONLY Eligibility is determined based on family size and income compared to Federal Poverty Guidelines. Patients will not be denied services based on an inability to pay.

Income Type	Amount	Expenses/Bills Type			Amount
Monthly Gross wages/unemployment -Income #1		Rent, house, or trailer payment			
Net wages after taxes - Income #1		Land/lot payment			
Gross wages - Income #2		Utilities	Gas	Water	
Net wages after taxes - Income #2		Food	Phone Bill		
Gross wages/salary - Additional Income		Car payment	Car Insurance		
Net wages after taxes - Additional Income		Car payment	Car Insurance		
		Child support/alimony payment			
Social Security check amount #1		Daycare/childcare expense			
Social Security check amount #2		Education/college loans			
Social Security check amount (child)		List of all insurance premiums paid:			
SSI Income (list amount & recipient)		Hospital/daily indemnity			
Military/Reserves Income		House/renters insurance			
Short/long term disability income		Health/ Medical insurance			
Unemployment check amount		Student insurance			
Retirement/pension check amount		Life/burial insurance			
Rental income receives		Cancer insurance			
AFDC/Family Assistance		Doctor and medical expenses (monthly)			
Church assistance received		Prescription costs (out of pocket)			
Other income or money received		Other expenses:			
TOTAL MONTHLY HOUSEHOLD INCOME:	$	**TOTAL MONTHLY HOUSEHOLD EXPENSES:**			$

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge and that no pertinent items of information have been concealed or omitted from this application. I also understand that HEALS Inc. has the right to reverse its decision concerning charity discounts when discovery of information is made that indicates the patient/guarantors has or had the ability to pay for their services. I am giving HEALS, Inc.; permission to access my credit file and to provide my financial information to those companies contracted by HEALS, Inc. for the purpose of financial or product recovery programs for which I may qualify. If there is anyone you would like to allow us permission to speak with regarding completing the financial application process, please list them below as a designated person in the space provided.

____   ____

Printed Parent/Guardian's Name   Parent/Guardian's Signature

Witness Signature ____ Date: _________________________________

REQUIRED DOCUMENTS

To apply for the Sliding Fee Discount Program, please provide **current proof of income**. Documentation must reflect your **most recent earnings** and may include **one** or more of the following:

- Most recent **income tax return** or **W-2 form**
- **Two most recent pay stubs**
- **Most recent unemployment check or benefits statement**
- Proof of **other household income** (such as Social Security, pension, disability, or child support)
- **Bank statements** showing direct deposits
- **Self-Declaration of Income Form**, only if no other proof of income is available.

If proof of *gross (before-tax)* income is not available, income may be **estimated based on net income** documentation.

Please fill out this form if you are authorized to have your child seen by the dental services at HEALS.

DENTAL Consent to Treat and Informed Consent

This form applies if your child (or children) have an appointment at the HEALS Dental Clinic, located at one of the schools we have partnered with to provide oral health services.

The appointment is to receive any of the treatments mentioned in the following list: dental cleaning, x-rays, sealants, Silver Diamine Fluoride, Varnish Fluoride, dental impression, dental evaluation, or exam.

If he/she/they require more specialized treatment, we will contact you to refer you to any of our other locations, for example:

- Martin Luther King Jr. Elementary HEALS Clinic (Huntsville, AL)
- Madison Cross Roads Elementary HEALS Clinic (Toney, AL)
- Madison County Elementary School HEALS Clinic (Gurley, AL)

Please write **your initials** in each line, and this will indicate that you agree

_____ I understand, agree, and give permission for the dentist and dental hygienist to provide care for my child at any HEALS Dental Clinic location, including the Mobile Clinic, Martin Luther King Jr. Elementary, Madison Cross Roads, and/or Madison County Elementary.

_____ I understand that by signing this document, healthcare providers may need to administer local or topical anesthesia and/or use nitrous oxide and oxygen as part of my child's dental care.

_____ I understand that multiple appointments may be required to complete treatment.

_____ I understand that my child may receive a small gift or sticker to acknowledge receiving sealants, local anesthesia, or a routine dental check.

_____ I understand that during a mobile clinic visit, dental cleanings will be provided. If additional treatment—such as sealants, restorations, extractions, or other procedures—is necessary, I will be informed and must provide consent before it is performed.

_____I understand that treatment may not be completed on the same day as the cleaning due to scheduling or other constraints.

_____I understand that if treatment cannot be performed in the mobile unit, I am responsible for taking my child to a follow-up appointment at a HEALS clinic location or another provider of my choice.

General Dentistry Informed Consent Form Risk and Alternative Treatment

Treatment Plan

I understand the recommended treatment as explained to me and acknowledge the receipt of a printed treatment plan listing the procedures to be performed. I understand that by signing this consent I am in no way obliged to permit any treatment for my child. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy follows routine restorative procedures.

Drugs and Medications

I understand that antibiotics, analgesics & other medications may be prescribed during dental treatment. These medications can cause allergic reactions such as redness & tissue swelling, pain, itching, vomiting, and/or anaphylactic shock.

Nitrous Oxide

I understand that Nitrous Oxide/oxygen inhalation (laughing gas) may be used during treatment. This is a mild form of conscious sedation used to calm an anxious patient. Some of the risks of Nitrous Oxide include nausea, vomiting, headache, nasal congestion or difficulty breathing through the nose, and temporary behavior issues in autistic patients. I understand that the use of Nitrous Oxide sedation does not guarantee that dental treatment can be provided successfully for my child.

Fillings

I understand that care must be exercised when chewing on teeth that have received newly placed fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional decay discovered during the process. I understand that sensitivity is a common after-effect of newly placed fillings. If sensitivity persists or is constant after the first week, please call for an evaluation.

Extractions

1) **Primary (baby) teeth:** When extracting primary teeth, the risks are less than that of adult teeth. However, there are some risks involved. It is possible to damage the newly formed adult tooth that is growing in to replace the baby tooth. There is also a

risk of infection or damage to adjacent teeth. In some cases, a small portion of the root may remain after the tooth is extracted, which could cause discomfort or infection.

2) **Permanent (adult) teeth:**

I understand removing teeth does not always remove the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are: pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue & surrounding tissue (paresthesia) that can last for an indefinite period of time, or fractured jaw. I understand the patient may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. Alternatives to the removal of teeth are root canal therapy, crown and bridge procedures, periodontal therapy, and orthodontics.

Sealants

I understand that, in some instances, my child may need sealants to help prevent decay on the chewing surfaces of back teeth. Risks of Sealants include but are not limited to breakage of sealants (common with certain habits such as grinding/clenching teeth and/or chewing ice or other hard foods/candy), failure or loss of sealants, and development of decay.

Crowns, Bridges, Veneers

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that my child will be wearing temporary crowns for a short period of time (stainless steel crowns do not require temporary crowns), which can come off easily, and that he or she must be careful to ensure that they are kept on until the final crown is delivered. I realize that the final opportunity to make changes (shape, fit, size, and color) will be before cementation. It is also my responsibility to ensure my child returns for cementation within 30 days of tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. An alternative treatment to a crown is to place a composite (tooth-colored filling), or an amalgam (silver filling), administer restoration, place a stainless-steel crown, or extract the tooth.

Endodontic Therapy

I realize there is no guarantee that root canal therapy will save my child's tooth and that complications can occur from the treatment. Occasionally root canal filling material may extend out of the root, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments, and therefore, stresses and defects in their manufacturing can cause them to break off in the root during use. I understand that, occasionally, additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. An alternative treatment to endodontic therapy is extraction of the tooth.

SDF Or Silver Diamine Fluoride

I understand that when SDF is applied, there will be permanent black staining in the treated area (which can be substituted with a filling or crown). Tooth-colored fillings or restorations and crowns may become discolored (they can usually be polished and the discoloration will decrease). The brown/white skin or gum stain (it is totally harmless, and disappears in 1-3 weeks), can leave a permanent mark if you or your child tries to remove it by rubbing other products on top of the stain. You may experience a temporary metallic taste. If there is no good hygiene, caries progression is possible (may require additional treatment). There is no guaranteed success with SDF treatment if there is no patient cooperation in encouraging good hygiene and improving eating habits. The alternative treatment to SDF is not to perform any treatment on the tooth or to restore it with resin or amalgam. I, further understand that dentistry is not an exact science, and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

This form must be completed and signed for one child only. Multiple children cannot be listed on the same form.

Patient's name ____ D.O.B _____________________________________

Parent/Legal Guardian Name: ____

Signature ____ Date: ____

Clinical Staff: ____