Southern Illinois Pediatric Dentistry of Edwardsville

Tooth Extraction Informed Consent

SOUTHERN ILLINOIS Pediatric Dentistry OF EDWARDSVILLE

Patient's Name: ______________________________________ Date of Birth: _________________

Why does the tooth need to be extracted?

There are multiple reasons a tooth may need to be removed. If a tooth becomes infected secondary to decay or trauma, it must be removed. Leaving the tooth untreated may result in pain, abscess, swelling and spread of infection. In other instances, an orthodontic specialist may recommend tooth removal to accommodate a more beneficial orthodontic outcome.

What are the risks and complications?

- **Pain or Discomfort**: This may occur at the site of tooth removal once the numbing sensation wears off. The patient may also experience stretching, cracking, or bruising at the corners of the mouth.
- **Damage to Adjacent Teeth**
- **Incomplete Root Removal**: Pieces of the root may be left behind if removing them poses a risk to the developing permanent tooth bud. If this occurs, the roots will often resorb on their own.
- **Bleeding**: Some bleeding may occur if the blood clot is disturbed. Applying pressure with gauze should stop the bleeding.
- **Space Loss**: When a baby tooth is lost prematurely, the adult tooth may not be ready to come into its position. This may result in space loss that may require orthodontic treatment to regain. Placement of a space maintainer appliance may be recommended to try and prevent as much space loss as possible. Your dentist will discuss your child's specific needs for space maintenance.

I understand tooth extraction is deemed necessary by the dentist, in the best interest of the patient's oral health. I understand that by refusing this treatment, the patient is at risk for pain, abscess, swelling and spread of infection.

I have read and understood the above. My questions have been answered. I understand this is an irreversible procedure and I give my consent for removal of the following tooth/teeth: #____________

Parent/guardian Printed Name: ___________________________________ Date: _________________

Parent/guardian Signature: _______________________________________

Dentist Signature:____ Date: ________________

Space Maintainer Recommended Y / N

NITROUS OXIDE INFORMED CONSENT

I hereby authorize **Southern Illinois Pediatric Dentistry of Edwardsville** to administer nitrous oxide for my child:

Child's Name: ____

1. I accept and understand that nitrous oxide (commonly referred to as "laughing gas") provides relaxation and reduction in anxiety.
2. I accept and understand that nitrous oxide is an elective procedure and is not required for the necessary dental treatment. However, other alternatives that may be required to safely and adequately complete the necessary dental procedure(s) include restraint (papoose board) or general anesthesia.
3. Please advise the doctor and staff of your child's complete medical history, including any surgeries. Advise them of any changes in your child's medical history, including if your child is currently ill.
4. Nitrous oxide is useful not only for anxiety control but can also be effective in controlling some mild to moderate gag-reflexes.
5. Nitrous oxide can have some (temporary) side effects including, but not limited to:
   a. Nausea and vomiting- although very rare, it may occur. It is not necessary to avoid eating leading up to the procedure but would not be advisable to eat a large meal immediately before the procedure. Remember that your child will likely be numb for 1-2 hours following the procedure and will be unable to chew any food during that time.
   b. Tingling of fingers and toes
   c. Feeling of warmth throughout the body
   d. Feeling of euphoria/uncontrollable laughing
6. Nitrous oxide is very effective for many children. However, it does not guarantee successful completion of all dental treatment if the child remains too active throughout the procedure.

I hereby certify that I understand this authorization and the reasons for the use of nitrous. I acknowledge that every effort will be made to ensure a positive outcome for my child's dental treatment. I further acknowledge that I have had the opportunity to discuss the use of nitrous oxide and that all questions have been answered to my satisfaction.

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Date Parent/Guardian Signature

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Date Witness

Southern Illinois Pediatric Dentistry of Edwardsville

Silver Diamine Fluoride Consent

SOUTHERN ILLINOIS Pediatric Dentistry OF EDWARDSVILLE

Patients Name: ______________________ **Date of Birth:** ______________________

The Facts:

- Silver Diamine Fluoride (SDF) is an antibiotic liquid used to stop tooth decay and reduce sensitivity.
- SDF is often needed to be applied initially every few weeks then every 6-12 months.
- SDF does not eliminate the need for a filling or crown. These are often still placed in order to restore function and esthetics. There is an additional costs for these procedures.
- Your child should not be treated with SDF if: they are allergic to silver, have any sores on the gums or anywhere in the mouth.

The Risks:

- The decayed area will stain black permanently. This area can usually be covered up with a filling or crown. Normal, healthy tooth structure will not stain.
- The edges of fillings may stain as well.
- If accidentally applied to the skin or gums, SDF will stain. The stain causes no harm and will only last a few weeks.
- SDF will cause a metallic taste for a few minutes after the procedure.
- The SDF may not stop the tooth decay. In this case, the tooth may need conventional treatment such as a baby root canal, stainless steel crown, or even extraction.

Alternative Treatment:

- No treatment is always an option. Unfortunately, this will likely lead to further deterioration and pain.
- Conventional fillings, crowns and extractions are all possible alternatives.

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED THAT MY INSURANCE DOES NOT PROVIDE COVERAGE FOR THIS PROCEDURE AND THAT I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL FEES INCURRED.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND THAT ALL QUESTIONS REGARDING THIS PROCEDURE AND ITS ASSOCIATED FEES HAVE BEEN ANSWERED.

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Date Parent/Guardian Signature

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Date Witness