DENTISTRY FOR CHILDREN

705.470.4100
admin@childrensdentistryclinic.ca
www.childrensdentistryclinic.ca

Consult Check List

- [ ] No eating for 8 hours prier to general anesthetic appointment.
- [ ] For appointments schedule at 3:00pm and later, food is allowed BEFORE 6:00 am.
- [ ] No drinking for 4 hours prior to general anesthetic appointment.
- [ ] Only clear fluid (you can see through them) between 4-8 hrs.
- [ ] Bring the blanket and liquid Tylenol into the office when you FIRST arrive for your appointment.
- [ ] I understand that treatment plans could change once x-rays are assessed. Teeth may require additional work (stainless steel crowns or even extraction)
- [ ] I understand that stainless steel crowns are the standard of care for primary teeth with cavities. White crowns are available in some situations but not all. They are not often covered by dental insurance. If you would prefer to have while crowns placed you are responsible for notifying the dental office before you schedule your appointment and that all fees are due the day of appointment.
- [ ] I understand my financial responsibilities regarding treatment and that costs can double once treatment plans are completed.
- [ ] I understand that I am responsible to inform the office of any changes in Insurance information or personal information.
- [ ] I understand and accept that I may incur unexpected out of pocket expenses if I do not communicate these changes.
- [ ] I understand that if I cancel or change a general anesthetic appointment with less than two weeks' notice, I will forfeit my deposit.
- [ ] No additional family members are able to enter the office during the appointment. 2 adult caregivers maximum per patient in the office.
- [ ] I understand that I must remain on the property the entire time the patient is in treatment.
- [ ] I understand that the Consultation Dentist may not be the Dentist that provides the dental treatment.
- [ ] I understand that the Treating Dentist will not leave my child's appointment to come and explain changes in treatment. By signing the treatment consent farm I agree to treatment changes.
- [ ] I understand that my/my child's appointment time is not the chair time with the dentist. There will be a nursing assessment done and then the anesthesiologist with speak with the patient/parents prior to going to the treatment room.
- [ ] I understand that appointments may begin later than anticipated. We understand that this is very frustrating and difficult. Please be patient. Treatment can and does change and this affects the amount of time required for each appointment. This is not something that can be determined beforehand. On occasion it can be more than an hour past your scheduled time.

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☐ I understand that no abuse of any sort (verbal, physical, etc) towards employees will be tolerated.

☐ I understand that I/we are responsible for keeping all insurance and contact information up to date.

I have read the form and understand the information provided. I had the opportunity to ask questions and my questions have been answered. I will contact the office if I have any additional questions or concerns.

Signature:

_____

Name:

_____

Date:

_____