HAPPY CHILDREN
PEDIATRIC DENTAL SEDATION CENTER

IV Sedation Contact Form

In order to keep your schedule IV time, **we must be able to confirm the appointment** and go over protocols with you in a timely manner. You will be contacted several times throughout this process.

Please list three forms of contact:

1. Name: _____
   Phone # _____
   Email: _____
   Relation to Patient: _____

2. Name: _____
   Phone # _____
   Email: _____
   Relation to Patient: _____

3. Name: _____
   Phone # _____
   Email: _____
   Relation to Patient: _____

*** You are authorizing us to disclose information to the above contacts about this appointment. ***

_____ _____
Printed Name of Parent/Guardian **Date**

_____ _____
Signature of Parent/Guardian **Date**

If we cannot confirm the IV Sedation appointment in a timely manner the appointment may be given to another patient*

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IV Sedation Medical Check List

Patient Name: _____ **Date**: _____

1. Does the patient have a history of seizures?
   Yes No
2. Does the patient have a history of heart problems/murmur?
   Yes No
3. Does the patient have a history of sleep apnea?
   Yes No
4. Has the patient seen any type of medical specialist/physician?
   Yes No
5. Is the patient allergic to eggs?
   Yes No
6. Does the patient have a history of asthma, bronchitis or any other breathing problem, or require asthma medication 2 times or more per week?
   Yes No
7. Does the patient have a history of hospitalization or surgeries?
   Yes No
8. Does the patient have a history of complications with anesthesia?
   Yes No

Please elaborate if you answered 'Yes' to any of the above:

_____
_____
_____
_____

List of medications / recreational drugs (Exp. CBD) taken by the patient:

_____

Week of IV Sedation appointment:

- **Must not have immunizations within 72 hours of appointment**
- **Must not have had a fever the night before the appointment**
- **Must not have had a breathing treatment within the last 30 days.**
- **Must not have had an Upper Respiratory Infection, or common cold within 2 weeks**
- **Must not have documented bleeding or bruising problems.**

_____ _____

Signature of Parent/Guardian **Date**

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Consent for Dental Treatment

The following information is provided to help make you better informed so that you may give or withhold your consent for procedures discussed. Please read this consent carefully and ask about anything that you do not fully understand.

With regard to my child _____, I_____ voluntarily request Dr. Jina Yoo and any other health care provider as she may deem necessary to treat my child's condition, which has been explained to me as Dental Caries.

I understand and consent to the following treatment that has been planned for my child:

___White Fillings ___White Crowns ___Stainless Steel Crowns ___Nerve Treatments (Pulpotomies)

___Extractions ___Space Maintainer ___Sealants ___Indirect Pulp Cap ___IV Sedation

And any other procedures including, but not limited to x-rays and the administration of local anesthetics, deemed necessary or advisable to the planned treatment.

Although their occurrence is extremely rare, some risks are known to be associated with the treatment or local anesthetic agent including, but not limited to: numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, breathing problems, brain damage, stroke, heart attack, or paralysis.

I understand that all efforts will be made to obtain the cooperation of my child with the use of warmth, friendliness, persuasion, humor, kindness, and understanding. I further understand and consent to the use of behavior management techniques to eliminate disruptive behavior or prevent my child from causing injury to themselves or the staff due to uncontrollable movements in order to facilitate the rendering of necessary dental treatment, including but not limited to nitrous oxide with oxygen (laughing gas), voice control, and minor forms of physical restraint, such as hand holding.

If I wish and exception (s) I have noted as follows: _____

(If you wish no exceptions, please write "NONE") _____

Alternative forms of treatment, as well as the option of no treatment have been explained to me with the advantages and disadvantages, risks and probable effectiveness of each.

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

_____ _____

Printed Name of Parent/Guardian **Date**

_____ _____

Signature of Dentist **Date**

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PEDIATRIC DENTAL SEDATION CENTER

Consent For the Use of Protective Stabilization

I, _____ authorize **HAPPY CHILDREN PEDIATRIC DENTAL SEDATION CENTER,** to use protective stabilization (papoose board) during dental treatment of my child:

PATIENT'S NAME: _____

The purpose of this restraint is to help prevent injury from untoward movements due to uncooperative behavior and/or sedation. I understand what the consequences of not using protective stabilization could be for my child.

I have discussed the above information and have been given an opportunity to have all my questions answered.

_____ _____

Printed Name of Parent/Guardian **Date**

_____ _____

Signature of Witness **Date**

HAPPY CHILDREN
PEDIATRIC DENTAL SEDATION CENTER

Scheduling and Broken Appointment Policy

for IV Sedation

We have strict scheduling regulations with IV sedation appointments. The office is only open to IV sedation patients on that designated day. There are several patients on a waiting list at any given time, who may need immediate attention. ***Missed or No-Show*** appointments causes a delay for other patients who may be on that waiting list.

Therefore, if you need to reschedule, you must do so, ***7 days (1 week) prior*** to the scheduled appointment. notice as a courtesy to other patients who may need immediate attention.
Failure to follow the following guidelines/pre-operative instructions will result in in broken appointment fee in order to reschedule.

Our current broken appointment fee is $ 350.00

*Please read the statements below and sign your initials to confirm that you understand our scheduling and broken appointment policy for IV sedation. *

_____ I agree to call and reschedule the appointment 7 days/ 1 week prior to the scheduled date.

_____ I understand that failure to comply with all pre-operative IV sedation instructions may cause a delay in rescheduling the appointment.

_____ I understand any missed or no-show appointments may result in dismissal from the practice.

_____ All payments made will be non-refundable if a **7 days/1 week prior** is not provided.

_____ I agree to follow all pre-operative instructions on the following ***appointment checklist form***.

_____ _____

Signature of Parent/Guardian **Date**

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Appointment Checklist

Please read the statements below and sign your initials

1. _____Patient **cannot** eat or drink after midnight, (11pm for 7am appts) the night prior to IV sedation.
2. _____Patient cannot attend school or daycare the day of sedation.
3. _____Patient will need to wear loose clothing. No long sleeves.
4. _____ Notify the office if your child is stuffy, coughing, sneezing, or have a runny nose, prior to the appt.
5. _____Bring a blanket for after the procedure.
6. _____Patient will need to wear a Pull up or Diaper (Under 5 years old)
7. _____Bring a change of clothing in case of accidents
8. _____Bring any medications the patient is taking. (Inhaler, seizure meds. Etc.)
9. _____A second adult to help with recovery is mandatory. This does not apply if you are planning to take a ride to and from your visit, and will be able to hold, and seat next to your child on the way back home
10. _____Other children will not be allowed in the office during an IV Sedation appointment, please make any arrangements necessary
11. _____There are long Wait Times
    - IV sedation is dental surgery that is done under the care of the anesthesiologist. This can be a lengthy process. Every child is different and may require extra time to place IV, take x-rays, etc. Some children also require x-rays causing a change in their treatment
12. _____Please expect to be in the office anywhere from **4-6 hours**
13. _____Your designated arrival time is **NOT** your appointment start time.

    We try our best to get each patient in and out in a timely manner. We appreciate your patience and understanding. We will do our best to communicate to you if we are running behind or if we can get your child in sooner.

_____ _____

Printed Name of Parent/Guardian **Date**

HAPPY CHILDREN
PEDIATRIC DENTAL SEDATION CENTER

Your tentative scheduled IV Sedation Appointment is on _____.

*****Please understand this scheduled appointment is contingent upon us receiving requested medical clearances and/or any other necessary paperwork and final review from the anesthesiologist*****

After the Appointment

Your child will wake up in your arms. Every child is different. Some children wake up groggy and quiet. Others wake up and are more vocal. Please rest assured this is normal and the patient will be monitored. We recommend to start the patient out with something light to eat. In most cases the child will be numb. Recommended foods are bananas, Jell-O, pudding, fruit smoothie, popsicles etc. Dairy products, greasy foods, and fast food are not recommended immediately after the appointment.

_____ _____

Printed Name of Parent/Guardian **Date**