

Consent for Paediatric Dental Treatment under General Anaesthesia

CHILD'S DETAILS

Full Name: _____ Date of Birth: ____ / ____ / ____

Address: _____

PROCEDURE DETAILS

Proposed hospital: _____ Date: ____ / ____ / ____

Treating Specialist Paediatric Dentist: _____

Please read the information below. Should you have any questions, please contact the practice to discuss these. Once you are satisfied and agree to proceed, please sign both the clinical and financial consent at the bottom of this form.

CONFIRMATION OF APPOINTMENT

In order to secure your child's treatment under general anaesthesia the following is required:

1. \$300 non-refundable deposit
and
2. Completion of this consent form

PROPOSED DENTAL TREATMENT

All efforts will be made to compile a provisional treatment plan prior to your child's dental appointment under general anaesthesia. The primary aim of this treatment is to return a child's mouth to health, including removal of infection and addressing pain/discomfort. Therefore, please note that the quote provided is an estimate only, as there can be changes to the treatment required on the day, for reasons such as:

- Progression of dental issues (e.g. decay and/or infection) between the initial examination and the day of treatment
and/or
- Further diagnosis of dental disease once radiographs (xrays) are taken while under general anaesthesia.

There may be need for additional fillings, extractions and/or other treatment to restore the child's dental health. This may include (but is not limited to) the following circumstances:

- Should tooth decay develop within the grooves of a tooth planned for a fissure sealant, then a filling may be required on the day.
- Should decay be evident on radiographs taken on the day, then appropriate treatment will be provided.
- Should tooth decay be present close to the dental pulp (nerve), one of the following treatment may be required: either:
 - Nerve treatment and a paediatric dental crown, or
 - Removal of the tooth
- Should the decay be more extensive than expected and the tooth not be suitable for a filling, a paediatric crown may need to be placed.

Your Specialist Paediatric Dentist will discuss recommendations and risks relating to the treatment at the consultation appointment, however should you have any additional questions prior to the treatment, please contact the practice.



DENTAL TREATMENT FEES

The dental fees outlined in the proposed treatment plan must be paid at least two weeks prior to the treatment date. Should the fees not be paid within this time, both the appointment time and deposit may be forfeited. Please note that the Child Dental Benefits Scheme (CDBS) under Medicare cannot be used for dental treatment provided under general anaesthesia.

Should any planned treatment not be required on the day, a refund will be provided to you.

If additional treatment is required on the day, payment for this is payable within 14 days of the surgery date. An itemised receipt will be provided to you to claim from your private healthcare insurance fund (if applicable).

Quoted fees are valid for three months only, after which point they may increase. Should there be a timeframe of three months or more between the consultation with the Specialist Paediatric Dentist and treatment, a second consultation may be required.

HOSPITAL & ANAESTHETIST FEES

Fees charged by the hospital and treating anaesthetist are entirely separate and in addition to dental fees. Please note that these fees, along with any questions relating to their services, should be directed to these providers.

ILLNESS OR CHANGES PRIOR TO THE TREATMENT

If your child becomes unwell prior to the day of treatment, please contact the Specialist Anaesthetist as soon as possible so that they can advise how to proceed. Should the Anaesthetist recommend that treatment be postponed, please know that we will rebook this for the earliest available session.

CLINICAL CONSENT FOR DENTAL TREATMENT UNDER GENERAL ANAESTHESIA

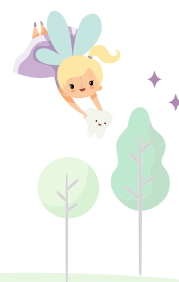
To be completed by the child's parent/guardian or other person with legal parental responsibility for the child upon careful reading of this form -

- I confirm that I am the parent/guardian or other person with parental responsibility for this child and have legal responsibility to consent for dental procedures for this child.
- Having had detailed discussions with the treating Specialist Paediatric Dentist, I confirm have had all treatment options, including no treatment, explained to me.
- I confirm that I have received a proposed treatment plan. The risks associated with the proposed treatment have been explained to me in full and I have had the opportunity to ask all questions relating to this.
- I have carefully read this form and confirm I understand that the treatment required on the day may change depending on the child's presentation.

Full Name: _____ Date: ____ / ____ / ____

Relationship to child: _____

Signature: _____



FINANCIAL CONSENT FOR DENTAL TREATMENT UNDER GENERAL ANAESTHESIA

To be completed by the child's parent/guardian or party responsible for the fees associated with the child's treatment upon careful reading of this form -

I acknowledge and agree that I am responsible for paying all fees associated with the treatment and confirm that I will pay those fees.

- In order to secure the booking, I understand that I need to pay a non-refundable fee of \$300.
- I understand that as outlined in this form, the proposed dental treatment plan is subject to change depending on the dental issues identified on the day of treatment. Any additional treatment will carry additional fees which I will be liable for.
- I understand that the fees charged by the hospital and anaesthetist will be billed separately to the dental treatment and will be payable directly to those entities.

Full Name: _____ Date: ____ / ____ / ____

Relationship to child: _____

Signature: _____

