BLACK HILLS Pediatric DENTISTRY
Where Bright Smiles Begin

Pediatric Dentists
William J. Donhiser, DDS
Brent J. Bradley, DDS
Kelli J. Jobman, DDS
Craig R. Cooksley, DDS

Adolescent & General Dentists
Jeffrey P. Godber, DDS
Daniel J. Clapper, DDS

Informed Consent for Surgery and Procedures

1. I hereby authorize staff physicians and resident staff at _____ (Name of Hospital) to perform upon _____ (Name of Patient), such treatment, procedures and/or operations necessary to treat or diagnose the conditions(s) which appear indicated. (Note: Rushmore Ambulatory Surgery Center, LLC ("RASC")and Same Day Surgery Center, LLC ("SDSC") are partly owned by physicians and meet the federal definition of a physician-owned hospital as specified in 42 CFR 489.3. A list of the Hospitals' physician owners is available upon request.)

2. The operation(s) or procedures(s) necessary to treat and/or diagnose my condition and the risks, benefits/alternatives and options associated with them have been explained to me by:
❑ Dr. Donhiser ❑ Dr. Cooksley ❑ Dr. Clapper ❑ Dr. Godber ❑ Dr. Bradley ❑ Dr. Jobman
and I understand the operation(s) or procedure(s) to be: **dental restorations and possible extractions**

3. **Different Provider:** I understand and approve that a different provider other than the physician may actually perform the procedure.

4. **Operative Side:** ❑ Left ❑ Right ☑ Not Applicable

5. **Sedation & Local Anesthetics:** I authorize the administration of sedation and the use of local anesthetics, drugs and medicines as may be deemed appropriate. If they will be used, the risks and benefits/alternatives of sedation have been explained to me by the procedural physician.

6. **Blood and Blood Products:** ☑ Not Applicable
I understand that certain surgeries, procedures or illnesses may result in loss of blood. I authorize the administration of blood and/or blood components during the procedure as well as during the course of my hospital stay. If blood will be used, the risks, benefits/alternatives have been explained to me by the physician.

   Patient/Responsible Person Initials: _____

7. **No Blood Products:** I request that NO blood derivative be administered to me. I hereby release the hospital/facility, its personnel, the attending physician and its agents from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives. The possible risks and consequences may occur as a result of my refusal.

   Signature of Patient/Responsible Person _____ Relationship _____

8. **Unforeseen Conditions:** It has been explained to me that during the course of the operation(s) or procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth above. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this operation(s) or procedure(s).

9. **Photography:** I consent to the use of photography, closed circuit television recording and to use the photographs and other materials for study, educational and scientific purposes, in accordance with practices of the facility. Initials_____

Physician Signature	Date/Time	Signature of Patient (if competent)		Professional Witness	Date/Time
Signature of Interpreter (if applicable)	Date/Time	Signature of Person Responsible/Relationship			Date/Time
Witness (Telephone consent)	Date/Time	Second Physician Signature for Emergencies for Incompetent Patient and No Family			Date/Time

Physician must initial faxed copy

American Academy of Pediatric Dentistry

ASDC American Society of Dentistry for Children

700 Sheridan Lake Road • Rapid City, SD 57702
Phone (605) 341-3068 • Fax (605) 341-5757 • www.bhpediatricdentistry.com

MEDICAL HISTORY

Patient's Name _____

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

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia/Low Blood Count	☐	☐	Hearing Impairments	☐	☐	Cystic Fibrosis
☐	☐	Heart Condition	☐	☐	Kidney Disease or Transplant	☐	☐	Blindness
☐	☐	Rheumatic/Scarlet Fever	☐	☐	Hepatitis or Liver Disease	☐	☐	Other Conditions:
☐	☐	Cancer, Malignancies or Leukemia	☐	☐	Child Abuse			_____
☐	☐	Asthma	☐	☐	Infection			
☐	☐	Diabetes	☐	☐	Cleft Lip/Palate			
☐	☐	Epilepsy, Seizures or Convulsions	☐	☐	Cerebral Palsy			
☐	☐	Hyperactivity/ADD	☐	☐	Birth Defects			
☐	☐	Psychiatric Care	☐	☐	Developmentally Delayed			
☐	☐	Latex Allergy or Sensitivity	☐	☐	Tuberculosis or Previous Positive Test			
☐	☐	Pain in Jaw Joints	☐	☐	Autism			
☐	☐	Excessive Bleeding/Hemophilia	☐	☐	Food Allergies? To what? Especially eggs. _____			

☐ ☐ Is Pre-Med necessary due to a heart condition or other medical reason?

☐ ☐ Is the patient currently taking any medication(s)? (If yes, please list)

_____

☐ ☐ Is the patient currently under the care of a physician? (If yes, for what?)

_____

☐ ☐ Is your child allergic or has your child ever had an adverse reaction to a specific medication? (If yes, which?)

_____

PLEASE LIST ANY TREATING DOCTOR (I.E. PEDIATRICIAN)

Type Of Doctor_____ Name _____ Office Phone _____

DENTAL HISTORY

Has your child ever suffered from any of the following conditions?

Yes	No		Yes	No	
☐	☐	Bad Breath/Halitosis	☐	☐	Dental Infection or Abscess
☐	☐	Bleeding Gums	☐	☐	Recent Dental Pain
☐	☐	Stained and Discolored Teeth	☐	☐	Missing or Extra Teeth
☐	☐	Cold Sores or Fever Blisters	☐	☐	Thumb/Finger Sucking
☐	☐	Dry Mouth	☐	☐	Dental Grinding/Clenching

☐ ☐ Do you wish to talk to the doctor privately about any special concerns?

☐ ☐ Has your child experienced any unfavorable reaction from previous medical or dental care? (If yes, please explain)

_____

☐ ☐ Injury or Trauma to Teeth, Mouth or Face (If yes, please explain)

_____

☐ ☐ Does your child receive fluoride supplementation from vitamins, water or tablet/drops?

How do you think your child will act toward the dentist?

☐ Cooperative ☐ Fearful ☐ Defiant ☐ Don't know

Parent/Legal Guardian Signature _____ Date _____

Take to Doctor's appointment 2-4 days prior to surgery

FAX COMPLETED FORM TO:

Black Hills Pediatric Dentistry, PC – 605-341-5757

SHORT FORM HISTORY & PHYSICAL

(May be used if H&P not dictated)

Patient Name: _____

Height _____ Weight _____

Chief Complaint/History of Present Illness: _____

Past Medical History: _____

_____

Past Surgical History: _____

Bleeding Disorders: ☐ No ☐ Yes _____

Drug and Food Allergies: _____

Current Medications: _____

Review of Systems:

Respiratory: _____

Vascular/Heart: _____

Ortho/Neuro: _____

GI: _____

GU: _____

EENT: _____

Endocrin: _____

Physical Examination (Specific to the procedure to be performed):

Note: Females need urine Hcg Test for anesthesia

Mental Status: _____

Lungs: _____

Heart:: _____

HEENT: _____

Neck/Lymph: _____

Abdomen: _____

Musculoskeletal _____

Neurological: _____

Other Findings: _____

Surgical Diagnosis: _____

Treatment Plan: _____

Diagnostic Test Results: _____

Pre-op Clearance? ☐ No ☐ Yes **Lab Tests Attached? ☐ No ☐ Yes**

Physician

Signature _____ Date _____

Printed

Name _____

PLEASE HAVE M.D. SIGN OFF

For questions, please call Black Hills Pediatric Dentistry at (605) 341-3068

Rushmore Ambulatory Surgery Center
620 Sheridan Lake Rd., Suite 104
Rapid City, SD 57702

Same Day Surgery Center
651 Cathedral Drive
Rapid City, SD 57701

PREPARING FOR YOUR DAY OF SURGERY

DO NOT allow your child to eat or drink anything after midnight the night before surgery unless instructed by your doctor. If your child has had anything to eat or drink, the surgery will be canceled. **NO GUM… NO WATER…NOTHING!**
$300 retainer/rescheduling fee will apply if your child eats or drinks anything after midnight.

DO NOT give your child any aspirin products two days prior to surgery date.

DO NOT discontinue any medications unless instructed to do so by your surgeon.

DO remove any fingernail or toe nail polish.

DO dress your child in comfortable, loose-fitting clothing. **Short sleeves** are preferred. We suggest pajamas or sweats. **NO SLEEPER PAJAMAS**.

DO feel free to bring a favorite toy or blanket & an extra set of clothes.

DO find alternative daycare for siblings to the patient. Siblings can be disruptive not only to your child but to other children having surgery that day. Your child will need additional attention from you the day of surgery.

DUE TO LIMITED SEATING in the waiting room, there is only enough room for two additional family members to accompany the patient. **NO MORE THAN TWO ADULTS PER CHILD.**

PLEASE BE AWARE that your child's surgery will take approximately 3 hours.

PLEASE BE AWARE that because anesthesia is being used, a parent or guardian must remain inside the surgery center for the duration of the appointment.

UPON ARRIVAL you will be greeted by a staff member and the admission process will be completed. You will meet with the nurse and she will prepare your child for surgery.

DURING RECOVERY: Your child will be moved to the primary recovery area when surgery is complete. After the first portion of recovery is complete, your child will be moved to our secondary recovery area. You will be able to sit with your child at this point while staff members complete the recovery process.

FOR FOLLOW-UP you will receive a phone call from the nurse to check in on your child's progress and answer any questions you might have.

Rushmore Ambulatory Surgery Center
620 Sheridan Lake Rd., Suite 104
Rapid City, SD 57702

Same Day Surgery Center
651 Cathedral Drive
Rapid City, SD 57701

Dear Parents:

As a result of the dental examination provided to your child today, it has been determined that your child has extensive dental treatment needs. It has also been determined that the best method of providing care to your child in a **more compassionate manner is under general anesthesia in a hospital setting.**

When an appointment is made to treat a child under general anesthesia in a hospital setting, it involves coordination of many health providers' time, and there are a limited number of appointments available to us each week to provide care to children in this manner. There are far more children needing this care than we have space for. If a parent elects not to keep an appointment for treatment under general anesthesia, this causes multiple problems:

1. It delays the treatment to be provided to your child and increases the chances that your child's dental treatment needs will become more severe and require more extensive treatment.
2. It deprives another child who requires similar care from receiving their care and causes them to suffer with toothaches and other dental problems.
3. It wastes the time of several doctors, nurses, dental assistants and other health care providers that could have been used to help another child.
4. It is extremely important that if you cannot make the appointment for your child's treatment needs under general anesthesia, that you notify our office immediately that you will not be coming for the appointment. WE REQUIRE TWO BUSINESS DAYS NOTICE TO CANCEL.

Because of the severity of problems incurred when a family elects not to show up for their child's dental treatment needs under general anesthesia, **we will require a deposit of $300 prior to making another appointment for treatment in the operating room**. This fee will also be charged if your child eats or drinks anything after midnight the night before, if we do not receive the History & Physical Form, signed by the physician, one day prior to surgery date OR we do not receive the required notice.

Signature of Patient/Responsible Person _____ *Relationship* _____

*Signature of Interpreter (if applicable)*_____ *Date*_____

This deposit will be refundable to you if you keep the new appointment for treatment under general anesthesia and the post-operative appointment. It will be refunded after your post-operative examination is completed. If you no-show for either the operating room appointment or the post-operative appointment, then the deposit becomes non-refundable and stays with Black Hills Pediatric Dentistry.

If you must change your child's appointment for treatment under general anesthesia or your child's post-operative appointment for any reason whatsoever, you must contact our office **immediately at (605) 341-3068**. If it is after normal business hours and you must cancel your child's appointment for any reason, you must contact our answering service at **(605)721-9231**.

Thank you for your attention to this matter.

Sincerely,

Surgery Coordinator