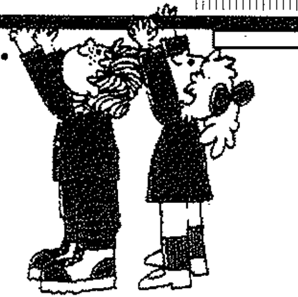
Brick Pediatric Dentistry

& Orthodontics, P.C.

132 Drum Point Road
Brick, NJ 08723
(732) 920-9220



SPECIAL CONSENT TO OPERATION

PATIENT'S NAME: ____

I hereby give permission to Dr. Seymour Semah and his staff to perform DENTAL REHABILITATION under general anesthesia. This includes dental restorations and or extractions as necessary. Dr. Semah has explained and I understand the nature, risks, and consequences of the procedure set forth therein above, as well as the alternatives to such treatment.

It has been explained that the risks of delaying treatment may result in serious dental infections and resultant complications. The tentative dental treatment shall include a prophylaxis, visual exam, x-rays, fluoride treatment and dental restorations and extractions as necessary.

We are uncertain of the extent of decay present in the teeth and it is possible that we may need to perform additional dental treatment including root canal therapy and place plastic or stainless steel crowns on these teeth. It is also possible that after we have removed all the decay form these teeth, we may find that there is not enough tooth structure to restore them. In such case, removal of these teeth will be necessary.

Dr. Semah has explained the risks involved with the use of general anesthesia (including the risks of cardiac arrest) and I consent to its use.

Print Name: ____

Signature: ____

RELATIONSHIP TO PATIENT: ______________________ DATE: ____________

WITNESS: ______________________________ DATE: ____________

PEDIATRIC DENTISTRY

Seymour Semah, D.M.D.
Diplomate American Board of Pediatric Dentistry
N.J. Spec. Permit # 5637

ORTHODONTICS

Tara Gostovich, D.M.D.
Diplomate American Board of Orthodontics
N.J. Spec. Permit # 5435

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Dear Parent or Guardian,

Please remember that the main reason that your child requires treatment in the hospital under general anesthesia is that we are unable to do a proper COMPLETE examination in the office. Amore thorough exam with all of the necessary diagnostic tools, including x-rays, can be done in the OR while your child is asleep.

We give you an estimate based on what we were able to see when your child was here. Sometimes this estimate is correct. Often, however, the hospital exam reveals additional and/or more extensive cavities. While your child is asleep, under general anesthesia, I will do the treatment I feel is most appropriate for him/her.

Please be aware that the total fee *can* wind up being **considerably** higher than that of the estimate. Unfortunately it is impossible for us to determine in advance exactly how much it will be.

We charge what we to be a fair estimate in good faith that you will pay the balance if there is one. If you prefer to pay a "worst case scenario" and be refunded the difference, we will be happy to do so!

Sincerely,

Dr. Seymour Semah

____

Print Parent/Guardian Name

____

Parent/Guardian Signature DATE

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Patient: ______________________ Date: ______________

Time: ________ AM PM

1. I hereby authorized Dr. Seymour Semah D.M.D ("Physician").

   Drs. ______________________ (the physician members of his medical group) and such assistants as may be selected to treat the following condition(s):

   Dental caries with possible pulpal involvement

2. (Cross out 2A or 2B as appropriate.) (Have patient initial.)

   A. I have indicated to the Physician that I do not wish to know the details of my case or the proposed treatment. I trust his/her professional judgement to do what is best for my care and treatment. (I hereby designate ______________________ as the person with whom my Physician may consult, as he/she deems advisable in deciding upon the course of treatment.)

   B. (1) The procedure(s) necessary to treat my condition (has, have been) explained to me by Dr. Seymour Semah and I understand the nature of the procedure to be:

   Dental restorations consisting of white plastic and/or silver fillings, stainless steel crowns, pulp treatment and or extractions, cleaning and x-rays as needed under general anesthesia.

   (2) It has been explained to me that there are alternatives to the aforementioned course of treatment including but not limited to:

   A. Restraining in office with patient awake.
   B. Sedation
   C. No treatment

   (3) I have been made aware of the risks and consequences commonly associated with the procedure(s) described above including but not limited to:

   All risks associated with general anasthesia

   (4) I have been told that if the procedure is not performed, what may happen to me is:

   Dento-alveolar infections

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SPECIAL CONSENT TO OPERATION OR OTHER PROCEDURE

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3. It has been explained to me that, during the course of the operation, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) that those set forth above. I, therefore, authorize and request that the above-named Physicians, their assistants, or their designees perform such surgical or other procedures as are necessary and desirable in the exercise of professional judgement. The authority granted under this paragraph shall extend to treating all conditions that require treatment and are not known to the above named physicians at the time of the operation or other procedure including without limitation to the administration of blood or blood products, of my own blood (if available) or blood provided by a blood bank, unless refusal of blood or blood products directive has been signed by me. (See Informed Consent to Transfusion Blood or Blood Products).

4. I have also been informed there are other risks such as severe loss of blood, infection, cardiac arrest, etc., that are attendant to the performance of any surgical procedure. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

5. I consent to the administration of anesthesia and the use of such anesthetics as may be deemed advisable by the physician of anesthesiologist responsible for this service to me. The anesthesiologist is not necessarily a physician named in #1 above.

6. I consent to the retention or disposal of any tissue parts which may be removed.

7. I certify that I have read and fully understand the above consent to operative procedure(s) that the explanations therein referred to were made to me by Dr. Seymour Semah, D.M.D ________________. And that all blanks and statements require insertion or completions were filled in and paragraphs which I do not want to apply, if any, were stricken before I signed.

____
Witness to Signature

____
Signature of patient or other person responsible

____
Witness to Signature

____
(Relationship) when patient is unable to sign or is a minor

PHYSICIAN'S CERTIFICATION

I, Seymour Semah, D.M.D ________________, M.D., certify that I have explained the specified operation(s) or procedure(s), the attendant risks and consequences, the alternatives, and the prognosis if the operation or other procedure is not performed, to the above named patient and/or other responsible person who has signed the above consent.

Date: ____________________

________________________ M.D.
Signature