DAVID CHING, D.M.D.
LAUREN YOUNG, D.D.S.
TIAN HE, D.M.D.

KIDSHINE PEDIATRIC DENTAL GROUP
PEARL CITY SHOPPING CENTER
850 KAM HIGHWAY, STE. 215
PEARL CITY, HAWAII 96782

TELEPHONE (808) 638-3313

CONSENT FOR TREATMENT

It is necessary for minor patients to be accompanied by an adult of legal age and who can also give legal consent for treatment at each appointment. If your child needs to have cavity work done and you would like to accompany them during the procedure, we kindly ask that you find child care arrangement for siblings.

It is our intent to provide the highest standard care for each child. Providing high quality care can sometimes be difficult because of the lack of cooperation from your child. Behaviors include: hyperactivity, aggressive or physical resistance, and refusing to open the mouth.

We make every effort to maintain the cooperation of young patients using positive reinforcements. We find one on one communication to be the most effective in building a trusting relationship with your child. There are occasions where additional behavior management may be required to gain cooperation from your child. The following is a list of behavior management techniques that are recommended by the American Academy of Pediatric Dentistry:

Tell-Show-Do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then how your child what is to be done by demonstration with instruments. Praise is used to reinforce cooperative behavior.

Positive Reinforcements: This technique rewards the child who displays any behavior that is desirable. Examples of rewards include compliments, encouragements, praises or prizes.

Voice Control: The attention of an uncooperative child is gained through lowering or raising the tone and volume of the dentist's voice.

Mouth Props a.k.a. "tooth pillow": A soft, rubber device is used to assist the child in keeping their mouth open during the procedure to prevent their jaw from getting tired.

Protective Stabilization: The dentist/assistant gently protects the child from movement by holding the child's hands, stabilizing the child's head and/or using a papoose wrap. The papoose wrap will be used only when necessary.

I have read this consent, and all my concerns were answered in a satisfactory manner. I give this office my permission to provide the highest standard of care for my child by using proper and acceptable methods to complete treatment. If my child has a change in his/her health, I will inform the doctor at the next appointment. At time no care will be rendered to a child without informing the parent or guardian of such care.

Parent/Guardian Signature: _____ **Date:** _____

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Patient Name: _____

CONSENT FORM

Prior to using or disclosing your protected health information to carry out treatment, payment of health care operations, **Dr. David Ching / Dr. Lauren Young / Dr. Tian He** are required under federal law to obtain your consent. Please review this consent. If you agree with its terms, please sign and date this consent below.

By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment or health care operations.

You have the right to request restrictions how your protected health information is used or disclosed to carry out treatment, payment or health care operations. However, we are not required to agree to such restrictions. If we agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent.

I,_____ *(Patient/Guardian),*
hereby certify that I have read the provisions set forth in this consent.

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

Print Name: _____

FOR DENTIST USE ONLY:

Signature of Recipient:_____ **Date Received:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, parent/guardian for _____,
Parent/Guardian Patient
have received a copy of this dental office's Notice of Privacy Practices.

Please Print Name: _____

Signature:_____ **Date:** _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barrier prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (please specify). _____

Dental Office Signature: _____ **Date:** _____