

General Information and Consent

Thank you for choosing us to help you keep your children healthy. We are committed to helping you provide specialty dental care for your children. We desire to make your child's visit both productive and pleasant. The information requested on this form is designed to help us diagnose and treat dental decay (cavities).

Initial Visit: Our goal is to provide a thorough Dento-facial examination including radiographs (x-rays). We will take radiographs on your child on this visit if he/she can cooperate with the assistant. Your child's teeth will be professionally cleaned and a prescription fluoride will be applied. Tooth-gum brushing instructions will be given to the patient and reviewed with the parent along with dietary recommendations. We only take radiographs thereafter to check for cavities and observe growth, or for other justifiable needs. We employ all procedures available to reduce radiation risk including a thyroid/gonadal lead apron, collimated x-ray machine and the fasted film available on the market today.

Behavior Management: Because of the fear associated with dentistry, it is sometimes necessary to use behavior medication techniques. We employ tell-show-do, voice control and hand holding. We will not physically restrain your child to obtain cooperation, except in case of emergency. For safety reasons, we do ask that siblings be left in the play area with responsible adult.

Please Let Us Know If You Object To The Use of Fluoride, Nitrous Oxide (Laughing Gas), Behavior Management and/or Radiographs (X-rays)

To better serve our patient we ask that you give us a 48 hour notice to cancel or reschedule an appointment.

Insurance is filed as a courtesy to our patients'; payment is required at time of service. We accept cash, Visa, MasterCard, Discover and Care Credit.

I hereby certify that Jeffrey D. Rhodes, D.D.S., M.S., F.A.A.P.D., P.A., a pediatric dentist, is authorized to release any information pertaining to the filing of insurance claims. I further authorize payment directly to the dental office of appropriate insurance benefits otherwise payable to me, and filed by the office on my behalf.

Parent or Guardian

Date

Other Individual That May Act as Legal Guardian
