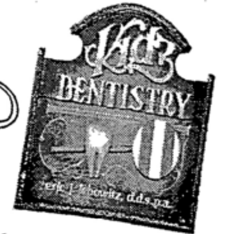
OUR PHILOSOPHY OF BEHAVIOR MANAGEMENT



One of the greatest challenges encountered by the Pediatric Dentist is gaining cooperation from young children.

Our training and knowledge of personality development and our years of experience in successfully treating children at Tooth Fairy-Land help us to achieve both cooperation and enthusiastic visits for dental care.

All efforts will be made to obtain the cooperation of your child by use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In spite of this, providing high quality, safe care can sometimes be difficult because the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper delivery of care are: hyperactivity, resistive movements, refusing to open the mouth or to keep it open long enough to perform treatment, and even aggressiveness or physical resistance to treatment, such as kicking, screaming, hitting, or grabbing the dentist's hands or the sharp dental instruments.

Because of these situations, we adhere to standards of behavior management found to be acceptable by members of the American Academy of Pediatric Dentistry. They are used in our office in the following order: "tell-show-do", voice control, a mouth prop, a papoose board or "pedi wrap" in selected cases as needed, and rarely, allowing the presence of a parent in the treatment area if it is requested by the dentist. We do NOT offer nitrous oxide sedation, general anesthesia, pre-medication, or hospitalization for "asleep" treatment. We choose to treat our patients in the office from the start. There is less expense, less risk, and presents the opportunity to mold acceptable behavior over time.

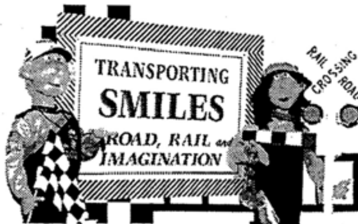
These techniques work wonders in our hands and the hands of our staff in relieving anxiety of the young patient. We all know that young children will cry when introduced into a new or strange environment - especially when factors such as noise, bright lights, vibration, pressure or manipulation occur. This conduct is common and is called "fear of the unknown". Some dentists have described normal crying as "loud cooperation". Describing procedures in terms your child can understand, and proceeding at a comfortable pace usually overcomes any anxiety very quickly.

Your child's safety and welfare are of utmost importance to us. Therefore, in cases where a struggling child might injure himself or a staff member, a papoose board may be used. This device is commonplace in most hospital emergency rooms and pediatric dental and medical offices. It provides gentle restraint that cannot be attained with an assistant attempting to hold arms, legs, or torso of the child. The use of a mouth prop or "tooth pillow" is sometimes necessary to prevent children from biting down on an instrument. It, too, is commonplace in pediatric dental offices.

From an early age, children can perceive when someone cares for them. If one can humor children, or capture their interest, cooperation is usually forthcoming. The use of voice control to gain a child's attention is very useful. For example, we can ask your child, "Are you married?" This, of course, is fantasy, and the child has an enormous capability to fantasize. The reactions and responses are really cute and serve to develop a rapport between dentist and patient. The only limitation with the use of voice control is one's imagination.

We truly enjoy practicing pediatric dentistry. We appreciate the exceptional privilege of providing dental services to children and in maintaining relationships that often span from early infancy to the end of adolescence - even into early adulthood.

I have read this philosophy statement. Initial, please. ________



Tooth Fairy-Land®

Members American Academy of Pediatric Dentistry and American Orthodontic Society

Specialists in Pediatric Dentistry for Infants, Children and Teens

Visit our Website at www.ToothFairy-Land.com

The Professional Centre • 9000 S.W. 87 Court • Suite 120 • Miami, Florida 33176 • 305-279-4312

CONSENT TO TREATMENT

Dear Parent,

In spite of the safe and caring dental treatment we are proudly known for at Tooth Fairy-Land, state law requires that I present you with the following information to obtain your consent for treatment. My staff and I will be unable to provide care to your child if any portion of this consent is altered. Thank you.

Sincerely,
Dr. Lebowitz

Patient's name ____

I understand that I will be provided with a "Treatment Plan" on the initial visit, describing in general terms, the dental procedures (and associated fees) for my child. A copy of that Treatment Plan is retained in my child's file; I will receive the original.

I understand that the treatment plan to be presented by Dr. Eric Lebowitz or a member of his staff, along with the fees outlined, could change depending on the time elapsed since the initial examination, the extent of dental pathology, or the presence of unknown, unforeseen or other conditions. When at all possible, I understand that I will be informed of any additional or different treatment prior to the performance of that treatment.

I, being the parent or guardian of the above named minor patient, hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. Lebowitz may deem necessary during treatment. No general anesthetics, sedatives, or tranquilizers are used in this office.

I understand that Dr. Lebowitz and such dentists or assistants as he may designate to treat the above-mentioned patient will use in general terms restorative, cosmetic, orthodontic, preventive (including cleaning the teeth and applying typical fluorides and sealants), oral surgery (including extractions), and patient management techniques that are reasonable, necessary, and advisable.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure. Due to individual patient differences, there exists the risk of failure, or relapse, or selective re-treatment or worsening of the present condition despite the care provided.

I authorize Dr. Lebowitz to request the release of any of my child's dental or medical records or x-rays, as may be needed, for his reference. I understand that dental procedures may be performed or withheld depending on the parent's (or guardian's) statements, medical history, or other information provided concerning the patient.

I also authorize the administration of LOCAL anesthetics (numbing medicine) or analgesics (pain medicine) which may be deemed advisable by Dr. Lebowitz. NO GENERAL ANESTHETICS will be used to totally "put my child to sleep".

Although their occurrence is EXTREMELY REMOTE, some risks are known to be associated with dental or oral surgery procedures. State law requires us to mention the RARE risks of numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, or allergic reaction.

I also authorize Dr. Lebowitz to use photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific or other publication. My child's identity will not be revealed without my permission.

I have read BOTH SIDES of this consent and understand, to my satisfaction, the procedures to be performed and the risks involved. I understand I will be given amply opportunity to ask questions about my child's Treatment Plan, the nature and purpose of the procedures and practical alternatives, and the expected outcome. Refusal of treatment will be notated in my child's chart along with the reason for refusal and the probable risks and consequences.

Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-named patient and affirm that I have the legal right to consent to treatment for this child.

Person completing this form (please print): Name ____

Relationship to child: ________________________ Signature ____________________________________

Today's date (M/D/Y) _____/_____/______ Witness ____________________________________

P.S. Thank you for your time and effort in accurately completing this registration information and for your cooperation and understanding in complying with Florida consent laws.

PLEASE RETURN THIS FORM TO THE RECEPTIONIST AS SOON AS IT IS COMPLETED