Children's Dental Columbia

Our doctors are members of the American Dental Association, American Academy of Pediatric Dentistry and are board certified by the American Board of Pediatric Dentistry. They follow their guidelines for treatment recommendations. They do not go against their recommendations simply because an insurance company may not cover a procedure. If they did so, they would not be providing the very best care for your child. Many employers select insurance plans for their employees that minimize the coverage of certain dental procedures. This does not mean that the procedures are not necessary. If parents desire not to have a procedure provided for any reason, it is necessary for the parent to sign a release so that our doctors will not be held responsible for any detrimental effects this may create.

As specialists in pediatric dentistry, our doctors feel very strongly that children should have routine x-rays including a panoramic x-ray every 3 years and bitewing x-rays every 6-12 months. These x-rays provide the ability to detect early cavities, cysts, extra teeth, missing teeth, infections, tumors, and other potential problems. No other reasonable option to dental x-rays exists at time. Our office's use of digital imaging and lead protective devices minimize the exposure of your child to radiation.

I am being provided this information and refusal form so I may fully understand the procedure(s) recommended for my child and the consequences of this refusal. I wish to be provided with enough information to make a well-informed decision regarding the treatment procedure(s) proposed.

I have received the above information about dental x-rays. I have been given the opportunity to ask questions and have them fully answered. I understand the risk in refusing these x-rays. I understand that the dentist may refuse to treat my child if I refuse diagnostic x-rays for my child.

Treatment procedures recommended by the dentist that I am refusing for my child:

___ Panoramic x-ray ___ Bitewing x-rays

Signed _____ Date_____

(Parent or Guardian)

Signed _____ Date _____

(Dentist or Office Representative)