COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
CASPER • DUBOIS • RIVERTON

# UNATTENDED CHILD POLICY ACKNOWLEDGMENT

***Your cooperation will be needed to help us provide the best possible dental care to your family. Please read our policies below and initial next to each statement.***

_____ I understand and am aware it is a courtesy to allow others to be present during treatment and only one (1) parent or authorized adult (i.e. guardian, power of attorney, spouse, etc.) will be allowed into the treatment area, there will be no siblings.

_____ I understand and am aware that clinic staff will not be responsible for unattended children in the waiting area and it is my responsibility to find appropriate supervision/care for my children if I choose to be present in the treatment area.

_____ I understand and am aware children may not be left in the waiting area while I am being treated and I must reschedule my appointment if I do not have appropriate supervision/care for the children.

_____ I understand and am aware that in order to respect patient and staff privacy, I will remain seated outside of the operatory at all times and will avoid wandering through the patient treatment area.

_____ I understand and am aware cell phone conversations are prohibited while in the treatment area. If my conversation or actions are loud and/or disruptive, I will be asked to return to the waiting area.

_____ I understand and am aware it is prohibited to take photographs while in the treatment area.

_____ I understand and am aware to refrain from conversation with the doctor and dental assistant while they are performing treatment. If I have any questions or concerns, I will try to address them at the beginning or end of the treatment encounter.

_____ I understand and am aware that should the patient become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and/or dentist to hold the patients hands, stabilize the head and/or control leg movements for their safety. I also understand that it is best to refrain from attempting to help control behavior and to stay seated.

_____ I understand and am aware in order to provide the delivery or safe dental care a referral to a Pedodontist may be suggested and appropriate contact information will be provided.

***By signing below I confirm that I have read and understand this form or it was read and explained to me and all my questions have been answered to my satisfaction.***

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Patient/Guardian Signature Date