

BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In The Matter Of:

LETITIA L. BALLANCE, D.D.S.)
(License No. 6485))

CONSENT ORDER

THIS MATTER is before the North Carolina State Board of Dental Examiners (Board) as authorized by G.S. 90-41.1(b) for consideration of a Consent Order in lieu of a formal administrative hearing.

Subsequent to an investigation conducted by the Board's Investigative Panel and allegations arising therefrom having been presented to Letitia L. Ballance, D.D.S. (Respondent), at a settlement conference on February 11, 2005 and continued on May 7, 2005, the Respondent enters into this Consent Order. While Respondent does not admit for any purposes the allegations contained in this Consent Order, in order to avoid additional proceedings, the Respondent agrees not to contest the allegations set forth within this Consent Order and does furthermore agree to the provisions and sanctions contained herein. Respondent further agrees that any breach or violation of this Consent Order shall constitute an admission of the findings of facts and conclusions of law as it pertains to the allegations contained herein.

FINDINGS OF FACT

1. Respondent is licensed to practice dentistry in North Carolina and is the holder of License No. 6485 originally issued by the Board on June 21, 1995 and duly renewed through the current year.

2. The specific allegations are affixed hereto as Attachment 1.

CONCLUSIONS OF LAW

1. Respondent has stipulated that such allegations, if proven, are legally sufficient to support findings and conclusions that he/she has violated G.S. 90-41 as specified in the Findings of Fact. Furthermore, Respondent has stipulated that, solely for the purposes recited herein, Respondent will not contest the allegations set forth in this Order, which allegations are previously incorporated in this Order, as if fully set forth herein, as findings of fact.

¶ ¶ ¶ ¶

IT IS, THEREFORE, ORDERED AS FOLLOWS:

1. License number 6485 issued to Respondent for the practice of dentistry in North Carolina is suspended for a period of one hundred eighty (180) days. Respondent shall surrender her license and current renewal certificate to the Board at its offices on or before December 9, 2005. During this term of suspension Respondent may, with the Board's prior written approval, lease her dental office and equipment. Any lease approved by the Board must be in writing and must disclose fully all material terms of the transaction. In no event shall any such lease allow operation of the dental practice on behalf of or for the benefit of Respondent.

2. With Respondent's consent, her license to practice dentistry shall be conditionally restored, with no active suspension, provided that for three (3) years she comply with the following probationary terms and conditions:

- (a) Respondent shall violate no provision of the Dental Practice Act or the Board's Rules;
- (b) Respondent shall neither direct nor permit any of her employees to violate any provision of the Dental Practice Act or the Board's Rules;
- (c) Respondent shall allow the Board or its authorized agent to inspect and observe her office, conduct random patient chart review, and interview her employees and co-workers at any time during regular office hours;
- (d) Respondent shall comply with all Medicaid regulations regarding the billing of dental services, including those regulations enacted in October of 2004. These regulations include, but are not limited to, a limit upon the billing for stainless steel crowns and/or pulpotomies to no more than six per patient on a given day and Respondent shall not perform more than six per patient on a given day;
- (e) Medicaid Dental Center (MDC) has modified its consent forms since the underlying complaints were filed to make absolutely sure that the parent or his/her guardian fully comprehends the scope and nature of the work to be performed and gives consent to this work. The current consent form being used by MDC is

attached as Exhibit A, and includes explicit language that the parent/guardian must read and sign indicating consent. MDC shall use this form when explaining the scope of treatment to a parent/guardian and obtaining consent;

- (f) If a papoose is to be used as an operative restraining device, the evaluating or treating dentist will show the parent/guardian a picture of the papoose (see Exhibit B), explain its use, and the parent/guardian will sign a form consenting to the use of this behavioral management device;
- (g) If a parent does not speak English, an appropriate interpreter will be used to make sure the parent/guardian fully understands the relevant consent forms;
- (h) The evaluating or treating dentist will document in the patient's file the surfaces where decay is clinically observed, either in the chart notes themselves or in pictorial representations. Digital photographs of decay shall be taken when radiographs are unavailable;
- (i) MDC will provide any patient records requested by the Board or its investigators upon written or verbal request by a member of the Board or a Board representative;

- (j) Within three (3) months of entering into this Order, MDC will sponsor an in-house seminar, featuring the use of an expert in the field who is not employed by MDC, to discuss the topic of current anesthesia practices as it relates to pediatric dentistry. A course description, number of hours, and the names and position of those employees in attendance at the course shall be submitted to the Board office immediately following the course;
- (k) Respondent shall, within thirty (30) days from the date of this Order, reimburse the Board for the costs associated with this investigation and hearing in the amount of \$ 5,850.00.

3. If Respondent fails to comply with any provision of this Order or breaches any term or condition thereof, the Board shall promptly schedule a public Show Cause Hearing to allow Respondent an opportunity to show cause as to why Respondent's license should not be immediately suspended per the terms of this Order. If as a result of the Show Cause Hearing, the Board is satisfied that Respondent failed to comply or breached any term or condition of this Order, the provisional restoration of her license shall be rescinded and upon written demand, Respondent shall immediately surrender her license and current renewal certificate to the Board for one hundred eighty (180) days. This sanction shall be in addition to and not in lieu of any sanction the Board may impose as a result of future violations of the Dental Practice Act or of the Board's Rules.

This the 12 day of December, 2005.

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

BY: Terry W. Friddle
Terry W. Friddle
Deputy Operations Officer

STATEMENT OF CONSENT

I, LETITIA L. BALLANCE, D.D.S., do hereby certify that I have read the foregoing Consent Order in its entirety and that I do freely and voluntarily admit, exclusively for the purposes of this disciplinary proceeding and any other disciplinary or licensure proceedings before this Board, that there is a factual basis for the allegations set forth therein, that these factual allegations, if proven, are legally sufficient to support findings and conclusions that I have violated G.S. Section 90-41(a)(12), and I will not contest the factual allegations therein should further disciplinary action be warranted in this matter, and that I assent to the terms and conditions set forth therein. I hereby express my understanding that the Board will report the contents of this Consent Order to the National Practitioner Data Bank and that this Consent Order shall become a part of the permanent public record of the Board.

This the 8 day of December, 2005.

Letitia L. Ballance, DDS

LETITIA L. BALLANCE, D.D.S.

ATTACHMENT 1 FINDINGS OF FACT

1. Respondent is licensed to practice dentistry in North Carolina and is the holder of License Number 6485, originally issued by the Board on June 21, 1995 and duly renewed through the current year.

2. At all relevant times, Respondent was engaged in the practice of general dentistry in Charlotte, North Carolina and is part owner of the Medicaid Dental Center (MDC) facilities. Medicaid Dental Center is a general dental practice that treats pediatric patients only.

3. Brandon Dillbeck was a patient at the Charlotte Medicaid Dental Center on June 5, 2003. During this appointment dentists employed and trained by MDC formulated a treatment plan and subsequently performed pulpotomies and placed stainless steel crowns on Brandon's teeth numbers A, B, C, D, E, F, G, H, I, J, K, L, M, R, S and T.

4. Alexander Marlowe was a patient at the Charlotte Medicaid Dental Center on April 22, 2003. During this appointment dentists employed and trained by MDC formulated a treatment plan and subsequently extracted Alexander's tooth A, placed restorations in teeth numbers B and G and performed pulpotomies and placed stainless steel crowns on teeth numbers D, E, F, J, K, L, S and T.

5. Tacora Warren was a patient at the Winston-Salem Medicaid Dental Center on June 23, 2003. During this appointment dentists employed and trained by

MDC formulated a treatment plan and subsequently performed pulpotomies and placed stainless steel crowns on Tacora's teeth numbers A, B, I, J, K, L, S and T.

6. Jonathan Myers was a patient at the Winston-Salem Medicaid Dental Center on August 5, 2002. During this appointment dentists employed and trained by MDC formulated a treatment plan and subsequently performed pulpotomies and placed stainless steel crowns on Jonathan's teeth numbers A, B, C, D, E, F, G, H, I, J, K, L, N, Q, R, S and T.

7. Hunter Mungo was a patient at the Charlotte Medicaid Dental Center on April 25, 2003. During this appointment dentists employed and trained by MDC formulated a treatment plan and subsequently extracted Hunter's tooth E, placed a restoration in tooth number J and performed pulpotomies and placed stainless steel crowns on Hunter's teeth numbers A, B, C, D, F, G, H, K, L, M, N, O, Q, R, S and T.

8. Tyler Hatchel was a patient at the Charlotte Medicaid Dental Center on June 19, 2003. During this appointment dentists employed and trained by MDC formulated a treatment plan and subsequently placed a restoration in Tyler's tooth number K and performed pulpotomies and placed stainless steel crowns on teeth numbers A, B, E, F, G, I, J, L, M, O, P, Q, R, S and T.

9. Caitlin Barker was a patient at the Charlotte Medicaid Dental Center on July 18, 2003. During this appointment dentists employed and trained by MDC formulated a treatment plan and subsequently extracted teeth numbers N, O and P,

placed restorations in teeth numbers M, K and T, and performed pulpotomies and placed stainless steel crowns on Caitlin's teeth numbers A, B, C, H, I, J, L, Q, R and S.

10. Respondent, as part owner of Medicaid Dental Center, was responsible for determining office policies and implementing such policies. Respondent, as part owner of Medicaid Dental Center, was also responsible for training the staff or making arrangements for the staff to be trained and familiar with all office policies.

11. Medicaid Dental Center's standard operating policy was to perform as much treatment as possible in one appointment for each dental patient.

12. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent's dental practice treated Brandon Dillbeck, Alexander Marlowe, Tacora Warren, Jonathan Myers, Hunter Mungo, Tyler Hatchel and Caitlin Barker required that a dentist only perform pulpotomies and stainless steel crowns when such treatment is warranted and supported by radiographs and/or appropriate diagnostic documentation.

13. Respondent violated the standard of care because dentists employed and trained at MDC performed pulpotomies and stainless steel crowns when such treatment was not always warranted and supported by radiographs or appropriate diagnostic documentation.

14. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent's dental practice treated Brandon Dillbeck, Alexander

Marlowe, Tacora Warren, Jonathan Myers, Hunter Mungo, Tyler Hatchel and Caitlin Barker required that a dentist not perform excessive dental treatment in a single appointment.

15. Respondent violated the standard by establishing office policies that resulted in dentists employed and trained by MDC performing excessive dental treatment in a single appointment.

Exhibit A

Exhibit B

CAROLINA DENTAL CENTER
3053-B FREEDOM DRIVE
CHARLOTTE, N.C. 28208
704.393-3911

CONSENT FOR PROTECTIVE IMMOBILIZATION

I, _____ have discussed the use of protective immobilization with my dentist and agree to the use of immobilization in order to complete needed dental care for my child, _____.

I understand the reason my child needs immobilization is the following: (check one)

- ___1. He/she requires immediate diagnosis and/or treatment and cannot cooperate, due to a lack of maturity.
- ___2. He/she requires immediate diagnosis and/or treatment and cannot cooperate, due to mental or physical disability.
- ___3. Either, my child and/or the dentist and staff would be at risk without the protective use of immobilization.

I understand the benefits of this procedure are:

- 1. Reduction or elimination of untimely movement.
- 2. Protection of the child and dental staff from injury.
- 3. Facilitate the delivery of quality dental treatment.

I understand there are no known risks to the immobilization procedure.

I understand that the alternative management procedures are sedation or general anesthesia, both of which have an increased risk of injury.

Parent/Guardian Signature

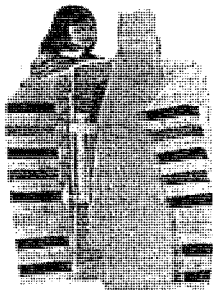
Date

Doctor Signature

Date

Witness Signature

Date



CAROLINA DENTAL CENTER
3053-B FREEDOM DRIVE
CHARLOTTE, N.C. 28208
704.393.3911

CONSENTIMIENTO PARA INMOVILIZACIÓN PROTECTORA

Yo, _____ he conversado sobre el uso de la inmovilización protectora con el dentista y estoy de acuerdo en usar dicha inmovilización para llevar a cabo el trabajo dental necesario en mi hijo/a, _____

Entiendo que la razón por la cual mi hijo/a necesita dicha inmovilización es la siguiente: (marque una)

- ___ 1. Él/ella necesita un diagnóstico inmediato y/o tratamiento y no coopera, dada su inmadurez.
- ___ 2. Él/ella necesita un diagnóstico inmediato y/o tratamiento y no coopera, dada su incapacidad mental o física.
- ___ 3. Tanto mi hijo/a como el dentista y su personal correrían riesgos sin el uso de la inmovilización protectora.

Entiendo que los beneficios de dicho procedimiento son:

- 1. La reducción o eliminación de movimientos inoportunos.
- 2. La protección del menor y del personal contra lesiones.
- 3. Facilitar el tratamiento dental de calidad.

Entiendo que el proceso de inmovilización protectora no presenta riesgos conocidos.

Entiendo que los procedimientos de manejo alternos son la sedación o la anestesia general, los cuales presentan un mayor riesgo de lesión.

Firma de los Padres/Custodios

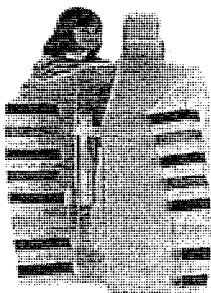
Fecha

Firma del Doctor

Fecha

Firma del Testigo

Fecha



WELCOME TO CAROLINA DENTAL CENTER

New Patient Information - Freedom

First Name	MI	Last Name	Date of Birth	Age	M	F	
Address		City	State	Zip	Phone #		Cell#
Social Security #		School		Grade	County		

Heart trouble	yes	no	Pregnant	yes	no	Asthma	yes	no
Heart murmur	yes	no	Anemia	yes	no	Diabetes	yes	no
Prosthetic joint/pin	yes	no	Bleeding	yes	no	Epilepsy	yes	no
Hepatitis	yes	no	Allergies	yes	no	Handicapped	yes	no
HIV/AIDS	yes	no	Rheumatic Fever	yes	no	Ulcers	yes	no
Tuberculosis	yes	no	ADHD/ADD	yes	no	Head Lice/Ringworm	yes	no
Surgeries	yes	no	Hospitalizations	yes	no	Other	yes	no

If you answered "yes" to any of above, please explain: _____

Does the patient have any dental problems/concerns at this time? _____

Does the patient require antibiotic pre-medication prior to dental treatment? Yes _____ No _____

Is the patient taking any medications at this time? Yes _____ No _____

If "yes", what type? _____

Is the patient allergic to any medications or materials commonly used in a dental office (latex gloves, anesthesia)?

Yes _____ No _____ If "yes", what kind? _____

PARENT/GUARDIAN INFORMATION

Mother/Guardian Name _____ Father/Guardian Name _____

Address _____ City _____ State _____ Zip _____ Home phone # _____ Work/Cell phone # _____

Nearest Relative not living w/ patient _____ Relationship _____ Phone # _____

***I understand I cannot leave the property while my child is being attended. If I leave, the proper authorities may be notified of my absence. I certify I have read and understand the above. I acknowledge my questions, if any about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist, or any other members of his/her staff responsible for any errors or omissions I may have made in the completion of this form. I have read and understand the DENTISTRY PATIENT MANAGEMENT TECHNIQUES on the reverse side of this form and give my consent for their use. I have received a copy of the CAROLINA DENTAL CENTER HIPAA NOTICE.**

Parent/Guardian Signature _____ Date _____ Doctor Signature _____

Dentistry Patient Management Techniques

It is our intent that all professional care delivered in our dental operations shall be of the best possible quality we can provide for each child. Providing high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open mouth or keep mouth open long enough to perform the necessary dental treatment, and even aggressive and/or physical resistance to treatment, such as kicking, screaming and grabbing at the dentist's hand or the sharp dental instruments.

All efforts will be made to obtain the cooperation of child dental patients by using warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

Methods used:

1. **Tell-Show-Do**: The dentist or assistant explains to the child what is to be done using simple terminology and repetition, and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. **Positive Reinforcement**: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.
3. **Voice Control**: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.
4. **Mouth Props**: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
5. **Hand-Over-Mouth Exercise**: The disruptive, screaming child is told a hand will be placed over the child's mouth. When the hand is in place, the dentist speaks directly into the child's ear and tells the child if the noise stops the hand will be removed. When the noise stops the hand is removed and the child is praised for cooperating. If the noise resumes, the hand is again placed over the child's mouth and the exercise is repeated.
6. **Physical Restraint by the Dentist**: The dentist restrains the child from movement by holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body or positioning the child firmly in the dental chair.
7. **Physical Restraint by the Assistant**: The assistant restrains the child from movement by holding the child's hands, stabilizing the head and/or controlling leg movements.
8. **Papoose Board and Pedi-Wraps**: These are restraining devices for limiting the disruptive child's movements to prevent injury and enable the dentist to provide the necessary treatment. The child is wrapped in the device and placed in a reclined dental chair.
9. **Nitrous Oxide**: Nitrous Oxide may be provided for your child. The patient **does not** become unconscious.

Note: If you do not agree with the above methods, please let us know so we may talk with you about them. Please realize it may not be possible to complete any dental work unless your child is in a safe environment.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

WELCOM JACK TO CAROLINA DENTAL CENTER

Patient Information - Freedom

First Name	MI	Last Name	Date of Birth	Age	M	F
Address	City	State	Zip	Phone #	Cell#	
Social Security #	School		Grade	County		

Heart trouble	yes	no	Pregnant	yes	no	Asthma	yes	no
Heart murmur	yes	no	Anemia	yes	no	Diabetes	yes	no
Prosthetic joint/pin	yes	no	Bleeding	yes	no	Epilepsy	yes	no
Hepatitis	yes	no	Allergies	yes	no	Handicapped	yes	no
HIV/AIDS	yes	no	Rheumatic Fever	yes	no	Ulcers	yes	no
Tuberculosis	yes	no	ADHD/ADD	yes	no	Head Lice/Ringworm	yes	no
Surgeries	yes	no	Hospitalizations	yes	no	Other	yes	no

If you answered "yes" to any of above, please explain: _____

Does the patient have any dental problems/concerns at this time? _____

Does the patient require antibiotic pre-medication prior to dental treatment? Yes _____ No _____

Is the patient taking any medications at this time? Yes _____ No _____

If "yes", what type? _____

Is the patient allergic to any medications or materials commonly used in a dental office (latex gloves, anesthesia)?
 Yes _____ No _____ If "yes", what kind? _____

PARENT/GUARDIAN INFORMATION

Mother/Guardian Name _____ Father/Guardian Name _____

Address _____ City _____ State _____ Zip _____ Home phone # _____ Work/Cell phone # _____

Nearest Relative not living w/ patient _____ Relationship _____ Phone # _____

*I understand I cannot leave the property while my child is being attended. If I leave, the proper authorities may be notified of my absence. I certify I have read and understand the above. I acknowledge my questions, if any about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist, or any other members of his/her staff responsible for any errors or omissions I may have made in the completion of this form. I have read and understand the DENTISTRY PATIENT MANAGEMENT TECHNIQUES on the reverse side of this form and give my consent for their use. I have received a copy of the CAROLINA DENTAL CENTER HIPAA NOTICE.

Parent/Guardian Signature _____ Date _____ Doctor Signature _____

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All efforts will be made to obtain the cooperation of child dental patients by using warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

Methods used:

1. **Tell-Show-Do:** The dentist or assistant explains to the child what is to be done using simple terminology and repetition, and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. **Positive Reinforcement:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.
3. **Voice Control:** The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.
4. **Mouth Props:** A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
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9. **Nitrous Oxide:** Nitrous Oxide may be provided for your child. The patient does not become unconscious.

Note: If you do not agree with the above methods, please let us know so we may talk with you about them. Please realize it may not be possible to complete any dental work unless your child is in a safe environment.

Parent/Guardian Signature

Date

CENTRO DENTAL CAROLINA

Informacion del Paciente - Freedom

Nombre _____ Apodo _____ Apellido _____ Fecha de Nacimiento _____ Edad _____ Sexo _____

Domicilio _____ Ciudad _____ Estado _____ Apdo. Postal _____ Tel Domicilio _____ Tel Cell. _____

de Seguro Social _____ Escuela _____ Grado _____ Condado _____

Problemas del Corazon	si__	no__	Embarazada	si__	no__	Asma	si__	no__
Hospitalizado	si__	no__	Anemia	si__	no__	Diabetes	si__	no__
Prosteticos	si__	no__	Sangramiento	si__	no__	Epilepsia	si__	no__
Hepatitis	si__	no__	Alergias	si__	no__	Incapacitada	si__	no__
HIV/SIDA	si__	no__	Fiebre Reumatica	si__	no__	Ulceras	si__	no__
Tuberculosis	si__	no__	ADHD/ADD	si__	no__	Piojos	si__	no__
Operaciones	si__	no__				Otro	si__	no__

Si contesto si a cualquiera de las preguntas, explique : _____

El paciente tiene problemas dental en estos momentos /O alguna preocupacion? Si__ No__

El paciente necesita medicina antibiotico antes de venir a su cita? Si__ No__

El paciente esta tomando medicina en estos momentos? Si__ No__

"Si", que tipo? _____

El paciente es alergico algun tipo de medicamento o materiales comunmente usados en la oficina dental(guantes,anestecia) Si__ No__ "Si", que tipo? _____

Informacion De Los Padres

Nombre De La Madre _____

Nombre Del Padre _____

Domicilio _____ ciudad _____ Estado _____ codigo postal _____ Tel: Domicilio _____ Tel:De Trabajo _____

Paciente mas cercano con diferente domicilio _____ Relacion _____ Telefono _____

*Yo entiendo que tengo que permanecer en la propiedad mientras mi nino esta siendo atendido. Si usted se va, se le notificara a las autoridades apropiadas. Estoy de acuerdo con la informacion mencionada.

*Mis preguntas, han sido claramente contestadas.El dentista o cualquier otro miembro de la oficina no sera responsable por algun error que yo haya hecho en esta forma.

*He leído y entiendo las Tecnicas de Mantenimiento del Paciente atras de esta forma.

*He recibido una copia de la carta de privacidad HIPAA del Centro Dental Carolina.

Firma de madre o padre _____

Fecha _____

Firma del Dentista _____

Uso de Técnicas Dentales al Paciente

Es nuestro interes es dar cuidado profesional en todos los operatorios de la mejor calidad posible para cada paciente. Dar cuidado de alta calidad puede ser muy difícil, enveces imposible por falta de coperacion de algunos pacientes. En los comportamientos que interfieren con las necesidades que dan la mejor calidad estan: niños hiperactivos, movimientos abruptos, negando abrir la boca o mantener la boca abierta suficiente tiempo para dar el tratamiento dental necesario, y resistencia física o agresiva, como gritando, pateando o tirando agarrones al dentista o a los instrumentos filosos que se usan.

Se intenta todo para obtener la cooperacion del niño siendo amigables y comprensivos.

Métodos usados:

1. **Explicar y enseñar:** El dentista o la asistente le explica al paciente el procedimiento con palabras sencillas y luego se le demuestra con un instrumento y un modelo de su boca. Despues se le hace el procedimiento en la boca del paciente como se le demostró. Si el paciente copera se le felicita y se le dice que esta haciendo muy buen trabajo.
2. **Control Vocal:** La atencion del niño que interrumpe es obtenida cambiando el tono de voz del dentista.
3. **Instrumentos Vocales:** Un instrumento de plastico es utilizado para mantener la boca abierta para los pacientes que tienen dificultades.
4. **Mano sobre Boca:** Cuando el paciente grita continuamente la mano del dentista cubrira la boca. Cuando esto sucede el dentista le habla al paciente al oido y de dice que va a quitar la mano cuando el ruido se acabe. Cuando el paciente deje de gritar se le dira que esta haciendo muy bien y que pronto terminara el procedimiento.
5. **Sostenencia:** El dentista o la asistente sostendrá las manos y el cuerpo manteniendolo inmovil a la silla.
6. **Cojin:** Estos son instrumentos que sostienen el paciente inmovil para limitar las interrupciones del paciente. Simplemente para evitar un accidente con los instruments filosos. El paciente es envuelto en estos cojines en la silla dental.
7. **Oxido Nitros:** Es disponible para su niño. El paciente no se hara inconsciente.

Sí ustes no esta de acuerdo con la lista de procedimientos porfavor haganos saber. Para poder responder sus prequntas o dudas. Pero comprenda que tal vez no es posible completar el trabajo dental para su niño en medio ambiente mas seguro.

Firma de madre o padre

Fecha

MEDICAL HISTORY UPDATE

Patient Name: _____ telephone _____

Address (new only) _____

Birth Date: _____ / _____ / _____

Date: _____ (To be completed by the patient or patient's agent)

I have reviewed my/the patient's MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

Signature of person completing this update: _____

If other than the patient, indicate relationship: _____

EXAMINING DENTIST'S COMMENTS/SIGNATURE: _____

_____ Date

Date: _____ (To be completed by the patient or patient's agent)

I have reviewed my/the patient's MEDICAL HISTORY, dated _____. My/the patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

Signature of person completing this update: _____

If other than the patient indicate relationship: _____

EXAMINING DENTIST'S COMMENTS/SIGNATURE: _____

_____ Date

Dentistry Patient Management Techniques

It is our intent that all professional care delivered in our dental operations shall be of the best possible quality we can provide for each child. Providing high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open mouth or keep mouth open long enough to perform the necessary dental treatment, and even aggressive and/or physical resistance to treatment, such as kicking, screaming and grabbing at the dentist's hand or the sharp dental instruments.

All efforts will be made to obtain the cooperation of child dental patients by using warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

Methods used:

1. **Tell-Show-Do**: The dentist or assistant explains to the child what is to be done using simple terminology and repetition, and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. **Positive Reinforcement**: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.
3. **Voice Control**: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.
4. **Mouth Props**: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
5. **Hand-Over-Mouth Exercise**: The disruptive, screaming child is told a hand will be placed over the child's mouth. When the hand is in place, the dentist speaks directly into the child's ear and tells the child if the noise stops the hand will be removed. When the noise stops the hand is removed and the child is praised for cooperating. If the noise resumes, the hand is again placed over the child's mouth and the exercise is repeated.
6. **Physical Restraint by the Dentist**: The dentist restrains the child from movement by holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body or positioning the child firmly in the dental chair.
7. **Physical Restraint by the Assistant**: The assistant restrains the child from movement by holding the child's hands, stabilizing the head and/or controlling leg movements.
8. **Papoose Board and Pedi-Wraps**: These are restraining devices for limiting the disruptive child's movements to prevent injury and enable the dentist to provide the necessary treatment. The child is wrapped in the device and placed in a reclined dental chair.
9. **Nitrous Oxide**: Nitrous Oxide may be provided for your child. The patient does not become unconscious.

Note: If you do not agree with the above methods, please let us know so we may talk with you about them. Please realize it may not be possible to complete any dental work unless your child is in a safe environment.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date