Kids First
Pediatric Dentistry

Dr. Andy Berman, D.M.D.
Specialty Permit #: 5814

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SURGERY CENTER INFORMATION

- All surgery center cases will be completed at the *Surgical Center of South Jersey*
  - Surgical Center address and phone: 130 Gaither Drive, Ste. 160, Mt. Laurel, 856-722-7000

- All children must be NPO (have nothing to eat or drink) beginning at midnight before their scheduled surgery.

- You will receive a packet of information from us. This packet will include:
  - Kids First Pediatric Dentistry Information, Consent, and Payment Authorization.
  - Patient History- *Please go to www.scasouthjersey.com Pre-Registration.*
  - Ambulatory Care History and Physical- MUST BE FILLED OUT BY YOUR PEDIATRICIAN WITHIN 30 DAYS of the surgery date. Please also obtain a copy of your child's up to date immunization record.
  - Information pamphlet about the surgery center including the date of your child's surgery.
  - All of this completed paperwork needs to be returned to our office no later than the Monday before the scheduled procedure. At this time we will also collect any portion not covered by your dental insurance, or amount owed if no insurance.

- If for any reason you need to cancel or reschedule, YOU MUST NOTIFY US NO LATER THAN 1PM ON FRIDAY BEFORE THE SCHEDULED SURGERY. Failure to do so will result in a $100 cancellation fee as well as moving the child to the bottom of the waiting list of surgery patients.

PROCEDURAL INFORMATION AND CONSENT

- During your child's surgery, we will take a full mouth series of radiograph's (x-rays) and complete all of your child's work, including any new cavities that we may find on the day of the surgery.

- The procedure that your child is undergoing is:
  - Complete Oral Rehabilitation to include Exam, Radiographs (X-Rays), cleaning, fluoride, Stainless Steel (Silver) Crowns, Composite (white) and Amalgam (silver) fillings, pulpotomies (nerve treatments), and extractions as deemed necessary.

- **ALL CAVITIES, INCLUDING ANY NEW CAVITIES FOUND THE DAY OF THE PROCEDURE, WILL BE FIXED.**

I hereby authorize Dr. Berman to perform the above procedure. I certify that I have read the description and all information provided to me and fully understand what will be performed.

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Signature Date