# CONSENT FOR DENTAL PROCEDURE
# and
# ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. State law requires us to obtain your consent to provide your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it.

I hereby authorize and direct Drs. Edward L. Donaldson, Jr., Jill Donaldson or Tessa Smith or any dentist in our employ and/or dental auxiliaries of his/her choice, to perform upon my child (or legal ward for whom I am empowered to consent) the following checked dental treatment or oral surgery procedure(s):

2. In general terms the dental treatment or procedure(s) will include:
   - ☐ A. Radiographs (x rays) of the teeth and jaws.
   - ☐ B. Cleaning of teeth and application of topical fluoride.
   - ☐ C. Application of plastic "sealants" to the grooves of the teeth.
   - ☐ D. Use of local anesthesia to numb the teeth and tissues.
   - ☐ E. Treatment of diseased or injured teeth with dental restorations (fillings, stainless steel crowns, pulpotomy).
   - ☐ F. Replacement of missing teeth with dental appliance.
   - ☐ G. Removal (extraction) of one or more teeth.
   - ☐ H. Treatment of diseased or injured oral tissues (hard and/or soft).
   - ☐ I. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
   - ☐ J. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures (papoose board).
   - ☐ K. Use of Nitrous Oxide to control apprehension and/or disruptive behavior.
   - ☐ L. Use of general anesthesia to accomplish the necessary treatment.
   - ☐ M. Other ______________________________

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The nature and purpose of the treatment and procedures have been explained to me in general terms by Drs. Edward L. Donaldson, Jr., Jill Donaldson, Tessa Smith and/or auxilliaries. Alternative procedures or methods of treatment, if any, have also been explained to me, as have their advantages, the risks, consequences and probable effectiveness of each, as well as the diagnosis if no treatment is provided. 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 treatment or as to cure. I further authorize the doctor to perform other dental service(s) that in his/her judgment are advisable for my child or legal ward, with the exception of (if no, so state) ______________________________

3. Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. <u>The most common complications with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia.</u> Less common complications include possible numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form, and extracted tooth or gauze packing, injury to the tongue and/or lips, damage to and possible loss of teeth and/or restorations (fillings), injury to the nerves near the treatment site, and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of subacute bacterial endocarditis (heart infection) following dental treatments exists. Therefore, antibiotics will be prescribed before and following treatment to minimize the risk.
I further understand and accept that complications may require additional medical, dental or surgical treatment and may require hospitalization.
Additional risks include ______________________________

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I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand further that I have the right to be provided with answers to questions which may rise during the course of my child's treatment.
I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time I choose to terminate it.

Patient's Name ______________________________

Signature of parent or guardian ______________________________

Relationship to patient ______________________________

Witness ______________________________

Presented by ______________________________

Date ____________________ Time am/pm ____________________