Pediatric Dentistry and Beyond

Request and Consent for Pediatric Dental Treatment

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Please read this form carefully! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it!

1. I request and authorize the treatment and procedures for:

   Patient Name: _____
   Date: _____

2. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).

3. I have had explained to me by the doctor, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

4. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

5. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's PLAN OF CARE and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives at the office of Pediatric Dentistry and Beyond.

6. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

7. **I understand** 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) to hold the patient's hands, stabilize the head and/or control leg movements.

(over)

8. For the purpose of advancing medical-dental education, I give permission for the use of clinical dental photographs of the patient for diagnostic, scientific, educational or research purposes.

9. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient.

10. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

11. **I confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

12. I have been advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all postoperative and post-care instructions be followed, and, that the regular office visits, as scheduled by my dentist, must be maintained.

13. I further understand that this consent will remain in effect until such time that I choose to terminate it in writing.

_____	_____
Signature of Person Consenting to Treatment	Date
_____	_____
Signature of Doctor	Date
_____	_____
Witness Certification	Date