Consent Form: Pediatric Dentistry

1) On (date) _____, **Dr. Lee** discussed with me the following informed consent form for dental treatment for the condition(s) described as:
_____
2) The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s) to be: _____
_____
3) The prognosis for this(these) procedure(s) was described as: _____
_____
4) I have been informed of possible alternative methods of treatment including:
   - **A.** No treatment at all
   - **B.** _____
5) I consent to the administration of local anesthesia in connection with the procedure(s) referred above, if necessary. I understand that administration of local anesthesia involves risks including pain, paralysis, injury and rarely, even death.
6) Complications with local anesthesia although rare can include swelling, bruising, pain, infection, nerve damage, and unexpected allergic reaction, which could lead to a heart attack, stroke, brain damage and/or death.
7) This form explains the care that your child needs, and request your permission to provide that care (please initial after reading and ask any questions, please ask your doctor BEFORE initialling).
   - **A.** _____ **Clinical Exam:** I understand the dental staff will perform an oral examination on my child and provide dental care based on the dentist's findings.
   - **B.** _____ **Emergency Exam:** I understand that emergency dental examination may be limited. An emergency exam is usually done to relieve the patient from swelling, bleeding, and injury. A referral to a specialist or other facilities may be necessary.
   - **C.** _____ **Dental x-rays**: Allows the dentist to diagnosis and treat conditions that cannot be detected during clinical examination such as caries (cavities), erupting teeth, pathology, plan orthodontics, and evaluate the results of an injury.
   - **D.** _____ **Dental cleaning:** Removal of plaque and calculus.
   - **E.** _____ **Fluoride:** Helps to strengthen the teeth and prevent caries (cavities).
   - **F.** _____**Dental fillings:** _____Tooth/Teeth**:** Decay dissolves the tooth, and if not treated can result in the tooth abscessing leading to pain and infection. The dentist will remove the decay and weakened tooth structure and replace it with an amalgam (silver) filling or a composite (white) filling to strengthen the tooth.
   - **G.** _____ **Sealants:** _____ Tooth/Teeth: Teeth have grooves and pits in which decay can start. The dentist or hygienist will "seal" the grooves with a plastic coating to prevent decay from starting.
   - **H.** _____ **Stainless Steel Crowns:** _____ Tooth/Teeth: If a tooth is badly destroyed by decay a crown or "cap" may be necessary. The tooth is trimmed around the sides and a preformed crown is placed over the tooth to prevent it from breaking.
   - **I.** _____ **Nerve or Pulp Treatment:** _____Tooth/Teeth: When decay or infection progress far enough that the tissue inside the tooth is infected, all or part of that infected tissue must be removed. This could take multiple visits. Pain or swelling after this work is rare and usually minor. Antibiotics may be needed to control possible

infections. After treatment a filling or crown will be placed to help prevent the tooth from breaking.

8) **Risks** included but are not limited to:
   - **A.** Despite all efforts by a general dentist, or a specialist, some complications could result, which include, but are not limited to:
     - **i.** allergic reactions to medications, materials or drugs used
     - **ii.** pain
     - **iii.** swelling
     - **iv.** infection
     - **v.** bleeding
     - **vi.** nausea
     - **vii.** vomiting
     - **viii.** paresthesia or long-term numbness

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of having a dental procedure performed and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning desired results of this procedure. The fee(s) for this service have been explained to me and are for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent (for my child) to allow and authorize Dr. Lee and/or any associates to render that treatment necessary or advisable to my dental conditions, including the administration and/or prescribing of any and all anesthetics and/or medications.

Patient's Name (please print):_____

Patient's (or legal guardian's) Signature: _____

Date/Time _____

Doctor's Signature: _____ Date/Time _____

Witness's Signature: _____ Date/Time _____