PATIENT NAME:_____

PEDIATRIC INFORMED CONSENT

1. **NITROUS OXIDE** - I authorize the doctor to administer nitrous oxide (laughing gas) to my child during his/her dental treatment. Nitrous oxide is used to help my child relax and make him/her less anxious. It is possible that my child may experience nausea as a result of nitrous oxide. (Initials _____)

2. **DRUGS, MEDICATIONS, AND SEDATION** - I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (sever allergic reaction). (Initials _____)

3. **CHANGES IN TREATMENT PLAN** - I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary, after having been informed and in agreement with the changes. (Initials _____)

4. **LOCAL ANESTHETIC** - I understand that the doctor will use a local anesthetic to numb the tissue around any tooth requiring treatment. The use of local anesthetic is necessary to control pain and discomfort during a dental procedure. Numbness may last for several hours following treatment and I understand that I must watch my child closely and follow all post-operative instructions to help prevent my child from biting his/her lip or tongue. Other risks associated with local anesthetic include possible allergic reactions, a black and blue mark at the injection site (hematoma), indefinite numbness of the injected area (parasthesia), or heart palpitations. (Initials _____)

5. **FILLINGS** - I have been advised by the Dentist that the silver amalgam restoration is an acceptable procedure according to ADA guidelines and, as such, is a treatment used by this office. The advantages and disadvantages of alternative materials have been explained to me. (Initials _____)

6. **REMOVAL OF TEETH (EXTRACTIONS)** - Alternatives to removal have been explained to me (fillings, crowns, root canal therapy, etc.) and I authorize the Dentist to remove teeth as indicated in my child's treatment plan. I understand removing teeth does not always cure infections, if present, and that additional treatment may be necessary. My child may experience pain, swelling, and bleeding as a result of the extraction(s). I will follow the post-operative instructions provided to me and agree to notify the office immediately if my child's condition does not improve as expected. (Initials _____)

7. **PULPOTOMY/PULPECTOMY (NERVE TREATMENT)** - I understand that a pulpotomy/pulpectomy is necessary when the decay in a tooth reaches the nerve. The procedure will prevent the tooth from becoming infected, or will help cure a tooth that is already infected. Doctors often refer to this procedure as a root canal on baby teeth. However, it is easier and faster for the doctor to do and is usually painless. If the pulpotomy/pulpectomy fails, I understand that the doctor may need to extract the tooth and place a space maintainer. If a pulpotomy/pulpectomy is not performed, my child may lose the tooth and the mouth may become swollen and infected. (Initials_____)

8. **CROWNS** - I have been made aware that my child needs to have a crown placed on one or more teeth. I understand that the doctor prefers to use stainless steel (silver) crowns because of their strength and reliability. As an option, I can request a white crown. However, I must discuss this with the treatment counselor and/or doctor to make sure that my child is a good candidate. Such procedures cannot always be done successfully. If I request a white crown and the doctor agrees, any insurance benefit that my child has may not cover the procedure and I may be responsible for the charges personally. Ask to see our crowns. (Initials _____)

9. **SPACE MAINTAINER** - I have been informed that a space maintainer is needed when a baby tooth is lost before it is normally ready to fall out. The space maintainer holds the space open so that the permanent tooth will be able to come in properly. If the space maintainer is not placed in the mouth, the teeth could shift causing the permanent teeth to come into the mouth in a crooked manner. When this happens, orthodontics (braces) may be required. While the space maintainer will not guarantee straight teeth, I understand that not using one could result in a more difficult orthodontic problem that is more expensive to treat and takes longer to fix. (Initials _____)

10. **ANTERIOR APPLIANCE** - I understand that an anterior appliance is used to replace missing front teeth and is important for several reasons. First, the appliance will help my child maintain a beautiful smile, ensuring that he/she does not become self-conscious about the way his/her teeth look. In addition the appliance facilitates proper chewing of foods. I also understand that the appliance is not necessary to hold space for future permanent front teeth. The teeth in the front tend not to shift and rarely create a problem for new permanent teeth. In general, the appliance is not recommended to replace a single missing tooth. I have been informed that the anterior appliance may not be covered by my insurance benefits, and I may be responsible for the charges personally. (Initials _____)

11. **USE OF RESTROOM** - I authorize the doctor or his/her staff to accompany my child to the restroom should the need arise. (Initials _____)

- I hereby request and authorize the dentists and their staff to perform dental work on my child for the purpose of attempting to improve the appearance, function, and health of his/her mouth, teeth, bone and tissue, as explained above.
- I also authorize the operating dentist and assistants to perform any other procedures which they may deem necessary or desirable in an attempt to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.
- I understand that the practice of dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment, which I have requested and authorized.
- I also understand that it is my responsibility to inform the dentist if I am having any problems during or following treatment so as to allow him to help minimize any problems.
- Alternatives and possible reactions have been explained to me clearly and in detail. Complications such as infection, hemorrhage, and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after the procedure, numbness or itching of the tongue, lips, teeth, tissues, parasthesia, fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT:

- I HAVE READ AND I FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT.
- ALL QUESTIONS ABOUT MY CHILD'S DENTAL TREATMENT HAVE BEEN EXPLAINED TO ME AND I UNDERSTAND THE EXPLANATIONS PROVIDED BY THE DENTIST AND/OR STAFF.

Parent/Guardian Signature_____ Relation to Patient _____ Date_____

Doctor Signature_____ Date_____