Pediatric Consent

As health care professionals, it is necessary that we obtain your consent for dental/oral treatment of your child. Please read this form carefully and ask any questions concerning anything that is not clear to you. We will be happy to answer any questions.

I, _____ **authorize** the doctors and their assistants to treat my child for all dental/oral procedures that may include but are not limited to:

- Dental cleaning, fluoride application, and radiographs as necessary.
- Application of sealants to dental fissures.
- Fillings for broken and decayed teeth.
- Treatment of infected teeth or gums.
- Root canal treatment of baby/adult teeth.
- Extractions of baby/adult teeth.
- Use of analgesia. (Nitrous oxide, local anesthetic)
- I understand all children must be accompanied by an adult, **and must remain in the office for all treatment.**
- I understand I must give 24-hour notice to cancel/reschedule an appointment. **After 3 missed/failed appointments, patient will be removed from the practice.**

My child's treatment, alternative methods of treatment and the advantages/disadvantages of each have been advised that although the best results are expected, there is no way within reason of anticipating complications. Therefore, it is not possible to guarantee the results of the treatment or the cure.

Although the occurrence is extremely remote, it is known that some risks are associated with dental procedures, including but not limited to: numbness, infection, damage to central nervous system, reduction or loss of function of internal organs and limbs, as well disfiguring scars. I understand and accept that certain complications may be fatal or require future medical intervention.

I have read and understand this policy.

_____ _____

SIGNATURE DATE

Child/ Children Name (s):