Children's Dental Health Associates

Consent to Perform Dentistry

1. I hereby authorize and direct the dentists of Children's Dental Health Associates and/or dental auxiliaries of their choice, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (X-rays) or diagnostic aids.

    A. Cleaning of the teeth and the application of topical fluoride
    B. Application of plastic "Sealants" to the grooves of the teeth
    C. Treatment of diseased or injured teeth with dental restorations (fillings) or crowns (caps)
    D. Replacement of missing teeth with dental prosthesis
    E. Removal (extraction) of one or more teeth
    F. Treatment of diseased or injured oral tissues (hard and/or soft)
    G. Pulp (nerve) treatment on one or more teeth
    H. The placement of sutures for wound closure
    I. The placement of splints or appropriate wound dressings
    J. The repositioning of one or more teeth
    K. Tooth bleaching

2. I agree to the use of local anesthesia, if required, on the judgment of the doctors. I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling, numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injections site), fainting, and lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

3. I recognize that, during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well being in the professional judgment of the dentists at Children's Dental Health Associates.

4. 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.

5. I hereby state that I have read and understand this consent, and that all questions about the procedure have been answered in a satisfactory manner; and, I understand that I have the right to be provided answers to questions which may arise during the course of my child's treatment

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

Patient's Name: ____ Date: _______/_______/___________

Name of Parent/Guardian:____Relationship to patient:______________

____
Signature of Parent or Guardian