MARLBOROUGH VILLAGE PEDIATRIC DENTAL CARE

INFORMED CONSENT FOR DENTAL TREATMENT

Patient's Name: _____ Patient's Date of Birth:_____

1. I have been informed of the need for my child to undergo dental treatment.
2. I have been fully informed about the details of the recommended treatment and alternatives, if any, as well as the advantages, disadvantages and risk of each, and the prognosis if no treatment is provided
3. I understand that my child will receive the following: □Teeth Cleaning □ Fluoride Application □ Radiographs (X-rays) □Fillings □Stainless Steel Crowns (Caps) □ Sealants □Extractions □Pulpotomies □Pulpectomies (Root Canals) □Local Anesthesia □Nitrous Oxide □Space Maintainer □Oral Sedation □Other_____
4. I understand that as treatment proceeds, there may be the need to change the treatment plan which may result in a change in cost and/or the number of required visits.
5. I confirm that I have provided an accurate and complete written health history for my child, including any medications my child is currently taking, as well as those to which he or she is allergic.
6. I understand that individual reactions during or following treatment cannot be predicted, and if my child experiences any unanticipated reactions during or following treatment, I agree to report them to the office as soon as possible.
7. I will follow any and all treatment and post-treatment instructions as explained and directed. I have been told that the success of the recommended treatment depends upon my cooperation in keeping the scheduled appointments, following home care instructions (including, but not limited to, oral hygiene and dietary instruction), and reporting to the office any changes in my child's health status as soon as possible.
8. I understand that there may be side effects from the dental treatment that may include, but not be limited to the following: infection, pain, swelling, bleeding, numbness, laceration of oral tissue, aspiration or swallowing of objects, and emotional upset.
9. For those patients having nitrous oxide: I understand that nitrous oxide (laughing gas) is going to be used with my child. I have been informed that my child will be fully awake, able to speak, understand, and answer questions. Further, I have been informed that it is used to make my child more comfortable and to help allay any fears or anxieties that my child have. I have been informed that any complications, if they occur, can include, but may not be limited to, nausea, vomiting, and drowsiness. A heavy meal within two hours of the appointment should be avoided. I consent to allow the use of nitrous oxide.
10. I have been informed that my child should not eat chewy or sticky foods and that doing so may result in failure of the fillings or crowns.
11. I have discussed all of the above and all of my questions have been answered. I further acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.
12. I realize that in spite of the possible complications and risks, including but not limited to those described above, my child's recommended treatment is necessary.
13. I understand that should the parent/legal guardian be unable to accompany the child (under age 18) for dental treatment, that written consent MUST be provided for an adult (age 18 or over) to provide consent for treatment on my behalf in my absence. The accompanying adult must also provide identification and be specifically named in the written consent by the parent/legal guardian. In the event that written consent cannot be obtained from the parent/legal guardian their absence, the child's appointment will be cancelled.

Following the explanation, discussion, and the answers to all my questions, I have read and understood this consent form and I authorize the recommended treatment. I agree to pay the charges incurred for my child's treatment.

_____ _____ _____

Signature of Parent/Guardian Relationship Date

_____

Witness Signature

I affirm that I have read the patient's health history and explained the proposed treatment and alternatives, if any, and the inherent risks of said treatment to the patient's parent(s) or responsible guardian(s).

Signature of Treating Dentist: _____ Date: _____