



INFORMED CONSENT FOR TREATMENT OF CHILD

This form is to obtain your consent for your child's dental treatment or oral surgery procedures. Please read this form very carefully and ask us about anything that you do not understand. Your child's dentist or the dental staff will be pleased to explain it. Thank you.

A. Below is a list of dental procedures that may be performed on your child. A treatment plan will be made for your child and presented to you after the initial examination. Prior to each appointment the specific treatment that will be performed on your child that day will be explained to you.

- 1. Diagnostic Procedures: Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
2. Teeth Cleaning: Removal of soft and hard deposits on teeth, and teeth polishing with special toothpaste.
3. Fluoride Treatment: A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay.
4. Dental Sealants: Plastic sealants are applied to the grooves of the chewing surface of newly erupted permanent molar teeth to help resist tooth decay.
5. Local Anesthesia Injection: 'Numbing medicine' carefully used to numb the teeth and surrounding areas prior to certain dental procedures such as tooth removal and dental fillings
6. Dental Rubber Dam: A sheet of latex rubber used to carefully isolate the teeth that need dental treatment.
7. Dental Fillings/Crowns: Depending on the size of tooth decay, and location of tooth in the mouth, the following may be done. Front teeth: white filling/crown. Back teeth or canine teeth: silver amalgam filling or stainless steel crown.
8. Pulp (tooth nerve) Treatment: A procedure to save baby teeth and certain permanent teeth that would otherwise be lost because of a deep cavity that has affected the tooth nerve. Saving a baby tooth that would normally be expected to remain in the mouth for nine months or more is recommended because it provides the child with a chewing surface. Also, baby teeth serve as natural space maintainers for the adult teeth growing underneath them.
9. Extraction ( Removal) of Teeth: Teeth may be removed because of infection, injury, orthodontic reasons (teeth crowding), or if they are diseased and cannot be saved by any dental procedures.
10. Space maintainer: Recommended when baby teeth are lost prematurely. Helps maintain the natural space intended for a permanent tooth by preventing adjacent teeth from drifting together and forcing permanent teeth to erupt in a crowded condition.

B. The nature and purpose of the treatment and procedures have been explained to me in general terms by the dental staff of Destiny Dental. Alternate procedures or methods of treatment if any, have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.

C. I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.

D. Risks and Complications: Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The more common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration of tissues, vomiting, allergic reactions, swallowing or aspiration of dental materials, an extracted tooth or gauze packing; injury to the tongue or lips, damage to and possible loss of existing teeth and or fillings, injury to nerves near the treatment site, and fracture of a tooth root which may require additional surgery for its removal. For children with certain heart diseases, the risk of Infective Endocarditis (heart infection) following certain dental procedures exists. Therefore, antibiotics will be prescribed before the treatment, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment that may require hospitalization.

E. I hereby acknowledge that I have read and understand this consent form. I have been given an opportunity to ask any questions that I might have. All questions about the procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my child's dental treatment. I also understand that I am free to withdraw my consent to treatment at any time. This consent shall remain in effect until I choose to terminate it.

Do you have any objections? Yes No
If yes, please explain?

F. By signing this consent form, I authorize and direct the dentists at Destiny Dental assisted by the dental staff of his/her choice, to perform upon my child (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained herein.

Today's date: Time:

Patient's Name: Date of Birth:

Printed Name of person completing form Signature of person competing form

Your relationship to patient: Are you legally responsible for this child? Yes No