Request and Consent for Pediatric Dental Treatment

Welcome to our practice. We are so glad that you have chosen our practice for your child's dental needs. Please read the information and sign below indicating that you have read and understand this form. If you have any questions regarding this form, please feel free to ask any one of our team members to assist you. We look forward to treating your child!

1. I further request and authorize the need to obtain dental x-rays considered necessary to treat my child's dental needs.

2. I understand that the treating provider will explain to me my child's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from the proposed treatment plan, compared with alternative approaches and/or no treatment.

3. 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. Any changes in treatment plans will be discussed with you prior to proceeding.

4. I understand that antibiotics, analgesics, and other medications may be used or prescribed during the course of treatment. I also understand the possible risks of such medications, including allergic reactions, causing redness and swelling, pain, itching, vomiting, and/or anaphylactic shock.

5. I understand it is important to monitor my child following treatment in which local anesthesia was administered. The length of time children will remain numb and unable to feel their cheek and/or lips, differs for every child. The possible risks include the child biting their lips or inside of their cheek.

6. Although it is extremely rare for any of the following risks or complications to occur, we do need to inform you of the possible risks/complications that may occur during the course of treatment. These risks or complications include but are not limited to: the possibility of pain or discomfort during treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

7. I understand it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion., humor, charm, gentleness, kindness, and understanding. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms that are appropriate for their age. Behavior will be guided using praise, explanation, and demonstration of procedures and instruments, using variable voice tone and loudness.

8. I understand that should my child become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant (s) and/or doctor to hold my child's hands, stabilize the head, and/or control leg movements for their safety. Additionally, I also understand that it is not uncommon for my child to cry before, during, and/or after dental treatment and the dental team will work on behavior management techniques to minimize my child's anxiety.

9. Nitrous oxide/oxygen sedation may be recommended for children who are unable complete treatment due to their behavior, ability to cooperate, and/ or restorative dental needs. A separate consent form for nitrous oxide/oxygen sedation will be obtained prior to treatment. I understand that most insurance plans do not cover the administration of nitrous oxide/oxygen sedation, and **I will be responsible for the entire fee for each visit in which my child receives nitrous oxide/oxygen sedation.**

10. It is also not uncommon for your dentist to recommend dental care performed under general anesthesia. For children who are unable to complete their dental treatment due to behavior, ability to cooperate, disabilities/special

healthcare needs, and/or extent of restorative care, treatment performed under general anesthesia may be recommended. A separate consent form and medical history form will be required prior to treatment.

This form will remain in effect until terminated by either this dental office or by you.

By signing below, you agree to the following:

- You are the legal guardian of this patient and are legally authorized to consent for treatment.
- You completely understand the information above.
- All of your questions have been answered to your satisfaction. You agree to the treatment plan proposed for your child.

Patient Name | Patient Date of Birth

Parent/Legal Guardian Name | Date

Parent/Legal Guardian Signature | Witness Signature