CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of ***Children's Dental Center*** to perform upon myself/my child (or legal ward) the following dental treatment or oral surgery/endodontic 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 resin "sealants" to the grooves of the teeth
   C. Treatment of diseased or injured teeth with dental restorations (fillings)
   D. Replacement of missing teeth or grossly damaged teeth with dental prosthesis
   E. Extraction (removal) of one or more teeth
   F. Treatment of grossly decayed, injured, or infected teeth with endodontic therapy (root canal)
   G. Treatment of diseased or injured oral tissues (hard and/or soft)
   H. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
   I. Cosmetic procedures including in office/home bleaching and veneers
   J. Postponing or delaying treatment at this time
   K. Use of nitrous oxide (laughing gas) to control apprehension
   L. Use of sedative drugs to control apprehension and/or disruptive behavior

2. I understand that there are risks involved in these procedures and acknowledge that these risks have been explained to me, that I have had an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen depending on the judgment of the doctors. I understand the nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose which disappears shortly after the procedure.

   I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the tissue. I also understand that there are rare potential risks such as unfavorable reactions to medications that may lead to respiratory and cardiovascular collapse that could result in coma or death.

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

5. 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 judgment of the dentists of ***Children's Dental Center***.

6. I have been advised that the success of dental treatment to be provided will require that the patient follow post-operative and post-care instructions of the doctor(s). I agree that the success of the treatment requires that all post-operative and post-care instructions will be followed and that regular office visits as scheduled by my dentist must be maintained.

7. I understand that scheduled visits are expected to be maintained by the patient/parent (or legal guardian) or cancelled with at least 24 hours notice. I have been informed that failure to maintain scheduled appointments may lead to unpredictable/unfavorable results of dental treatment.

All patients **under the age of 18 years old** must have the consent form reviewed and signed by a parent/legal guardian**.**

Date**:**_____

***Print Patient's Name*:**_____

Patient/Parent (Legal Guardian) Signature:_____