

# Children's Smile Center

## Consent for Treatment

As responsible party for (patient name) \_\_\_\_\_, I hereby give consent for the following dental treatments and evaluations performed by the dental professionals of the Children's Smile Center (CSC).

- Cleanings, including application of fluoride treatment
- Sealants
- X-rays, for evaluation and diagnosis
- Fillings
- Extractions
- Caps or Crowns
- Space maintainer placement
- Nerve treatments, including pulpotomies and root canals
- Use of Nitrous Oxide, for patient comfort

I understand that I am welcomed and encouraged to share in my child's initial visit and evaluation by joining him/her in the treatment area; however, in an effort to facilitate the doctor-patient relationship, I understand that all children are asked to come back for restorative treatments by themselves. The CSC requests that parents respect this decision and encourage their children's independence and I will respect this request.

I understand that all treatment plans will be discussed with me prior to beginning treatment, including the anticipated outcome if treatment is not obtained. I am free to ask any questions regarding the treatment and after-care of my child. I understand that dental procedures can be unpredictable. My child's cooperation, post-operative care provided at home, as well as, follow-up continuing care impact successful treatment. There is no guarantee of the outcome of procedures performed. For best results and to reduce future dental problems, I will do my part by ensuring that my child is:

- brushing twice a day and flossing daily;
- reducing his/her sugar intake; and
- present to all future appointments.

I further understand that treatment may be discontinued for patients, due to certain circumstances:

- Failure to keep 2 appointments without a 24 hour notification
- Continual tardiness to assigned appointment times; and
- A non-cooperative or poor behavior during treatment or to staff

It is also understood that treatment plans may sometimes be altered. Some teeth may require more or less treatment than estimated during the initial exam. All dental procedures are accompanied by inherent risks. Possible complications may include, but are not limited to:

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| • Bruising   | • Infection  |
| • Swelling   | • Broken root tips   |
| • Pain   | • Sinus exposure   |
| • Bleeding   | • Broken instruments   |
| • Numbness in the lip or tongue<br>(rarely, but sometimes permanent) | • Need for additional surgery or<br>referral to a specialist |
| • Pain in the jaw joint  |  |

I understand all risks and procedures to be performed. All of my questions have been answered and I consent for treatment to be performed on my child by the dental professionals of the Children's Smile Center (CSC).

Name: \_\_\_\_\_  
PLEASE PRINT

Relation to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_