INFORMED CONSENT FOR DENTAL TREATMENT

river city
pediatric dentistry

Patient_____ Date:_____/_____/_____

1. The doctor has explained, after examination, that my child's dental condition is:

   Decay **Periodontal (gum) disease** **Abscess** **Bite problems**

   Esthetics **Over-retained tooth**

2. The doctor has advised me that the following treatment is suggested:

   Filling- White/Silver **Stainless steel crown** **Sedative filling** **Bonding**

   Extraction **Nerve treatment** **Disking/Occlusal adjustment**

   Braces **Pan X-ray** **Bitewing X-rays** **Periapical X-rays**

   Space maintainer

   Space maintainers

   -With nitrous oxide analgesia and local anesthesia

   The doctor also recommends:

   _____ Sealants on permanent teeth

   I would like _____ sealants done today

3. The doctor has advised me that if I don't have this treatment done, I can expect the following consequences:

   Pain **Swelling** **Infection** **Tooth loss** **Jaw problems** **Bite problems**

4. The doctor has advised me of optional treatments. These options are:

   Do nothing **Place a filling** **Extract the tooth** **Nerve treatment** **Crown**

   Bond the tooth

5. Dental surgery, extraction: Alternatives to removal of the teeth have been explained to me (nerve treatment and no extractions). I understand that removing teeth does not always remove the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time, fractured root tip or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions such as redness and swelling tissue, prolonged numbness, pain, itching, vomiting, and/or anaphylactic shock.

I realize that it is mandatory that I give as accurate and complete a medical and personal history as possible, follow any and all instructions as directed, and permit prescribed diagnostic procedures.

I certify that I have read and understand the authorization for the treatment my child is about to have done. I accept the risk of harm, with the hope of getting the benefits the treatment might bring. I have completed the areas that need to be filled in. I have had the opportunity to ask questions and my questions have been answered to my satisfaction.

_____ I accept the above treatment **_____ I decline the above treatment**

PAYMENT IS DUE AT TIME OF TREATMENT

If I have a balance due today, I will be paying by the following method:

___ Cash ___ Check ___ Credit/Debit Card ___ Care Credit

Signature of
Parent/Patient:_____ Print Name: _____

Legal Guardian: _____

Doctor: **LAIS DALMAGRO PERUCHI, D.D.S.**

Witness: _____

Date: _____