Informed Consent

To perform dental work on my child

My child may have: **PLEASE CIRLE ALL THAT MAY APPLY**

CLEANING FLUORIDE X-RAYS EXAMS FILLINGS EXTRACTIONS

Although every effort will be made to adhere to the proposed treatment plan, unforeseen circumstances or conditions may require a departure from the plan.

After treatment, your child may experience pain and swelling. There is a possibility that the child may bite the inside of the mouth or tongue before anesthesia wears off, and that the child must be instructed not to do so.

Some of the possible side effects of local anesthetic are prolonged or permanent numbness of the cheeks, lips, tongue, or gums, allergic reaction, rapid heart rate, or a reaction with other drugs that are being taken.

If I do not remain in the dental office while my child is receiving dental treatment, I am leaving the treatment up to the doctor's judgment and experience, understanding that other treatment may have to be rendered if contact with me is not successful the doctor and staff have my permission to do whatever they feel is necessary. In case I need to be contacted during my child's dental visit, my cell phone number is _____.

Child's Name: _____

Parent or Guardian's Name: _____

Date: _____

Person(s) that will be bringing patient to appointment:

_____

_____

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