

CONSENT to PERFORM DENTISTRY

I hereby authorize and direct the dentists of **Starting Point Dental**, to perform upon my child, _____ the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids effective today and to include future dates for the duration of said patient's treatment at Starting Point Dental.

- A. Cleaning of teeth and the application of topical fluoride.
- B. Application of plastic "sealants" to the grooves of the teeth.
- C. Treatment of diseased or injured teeth with dental restorations (fillings).
- D. Replacement of missing teeth with dental prosthesis.
- E. Removal (extraction) of one or more teeth.
- F. Treatment of diseased or injured oral tissue (hard and/or soft)
- G. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
- H. Postponing or delaying treatment at this time.
- I. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

I understand that there are risks involved in this treatment and hereby 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.

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

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages, and risks of each. I am advised that though good results 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 results of the treatment or as to the cure.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorized and request the performance of any additional procedures that are deemed necessary or desirable to the child's oral health and well-being in the professional judgement of the dentists of Starting Point Dental.

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, face 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 mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping or breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

I am aware that it is sometimes extremely difficult to perform dental treatment on a child because of lack of cooperation. This is fairly common in very young and immature children, in those children with physical and/or mental handicaps which diminish their ability to cooperate fully with the procedures and in children who are fearful or anxious. I hereby authorize the use of a papoose board, the use of a mouth prop and the assistance of a dental auxiliary in holding the child, if in the doctor's opinion, the child needs to be restrained during treatment for his/her safety.

Parent (or Legal Guardian) _____ Date _____

Witness _____