CONSENT FOR DENTAL TREATMENT

Patient _____

1. I request and authorize Drs. Morgan and staff to perform or assist in the performance of the following but not necessarily limited to:

   - ○ Emergency Dental Treatment ○ Fillings
   - ○ Cleanings, X-rays, Fluoride treatments
   - ○ Sealants
   - ○ Extractions/Oral Surgery
   - ○ Space Maintenance/Interceptive Orthodontics ○ Crowns

2. The purpose of the above is to maintain dental health and we anticipate that result. No guarantees or assurances can be made as to the results that may be obtained.

3. Bleeding, swelling, discomfort and bruising can occur after any dental procedure. The risk of not completing necessary dental treatment can result in abscess, infection, pain, fever, swelling and substantial risk to the developing permanent teeth.

4. I understand that unforeseen conditions or circumstances may arise during the course of the above-described procedure or treatment. Hence, I consent to and authorize the performance of any care, procedure, or treatment not specified above that the dentist reasonably believes necessary or advisable as a result of these unforeseen events.

5. I understand that to facilitate my child's treatment a sedative may be required. I understand that sedation may prove partially or completely ineffective.

6. Additionally, I consent to the administration of local anesthetic that the dentist deems necessary, and/or nitrous oxide. I understand that the risks involved with the administration or local anesthetics may also be characterized by excitation, depression, nervousness, dizziness, blurred vision, tremors, drowsiness, and convulsions (seizures). Allergic reactions may occur which may be characterized by skin eruptions, itching, and swelling. I understand that the alternative of not using local anesthetic would probably cause a great deal of discomfort. The risk of this alternative could be emotional damage.

7. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand that treatment in terms appropriate for their age. To accomplish this, the patient's behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

8. I understand that should the child become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot be safely provided. During such movements, it may be necessary to use physical restraints such as a papoose board. I authorize the use of physical restraints, when deemed necessary to avoid possible injury to the child.

9 **I understand that I may refuse any and all treatments**. I have crossed out and initialed anything that I would refuse to consent to.

10 I certify that I have read and understand the above. I accept the risk of substantial and serious harm, if any, in hope of obtaining the desired beneficial results of this treatment or procedure

11 I understand that I am responsible for all fees incurred in relation to this child. This office will also assist in the prompt filing of all insurance forms as it applies.

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PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY (SIGNATURE)

RELATIONSHIP TO PATIENT(S) _____ **DATE** _____/_____/_____

MM DD YY