

## Informed Consent for Pediatric Dental Treatment

Patient Name: \_\_\_\_\_

Please read this form *carefully!* If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it! Our goal is to prevent decay and have all of our patients "cavity-free"!

1. I request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).
2. The usual and most frequent risks or complications occurring from the planned treatment and procedures include, but are not limited to the following: the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.
3. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's Treatment Plan and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.
4. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
5. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be *safely* provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.
6. **I further understand** that should the patient become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a "hug blanket" or "papoose board" to prevent injury and enable the dentist to *safely* provide the necessary treatment. This will not be used without your prior knowledge and additional written consent.
7. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.
8. I give my permission to take a picture of my child for identification for future appointments and for displaying their pictures on the bulletin board.
9. I give my permission for photo(s) of my child to be displayed on High Point Pediatric Dentistry's Facebook or webpage. These photos would only contain your child's first name and/or comments. I can revoke this permission at any time, or ask that the photo be removed from the site at any time.
10. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
11. **I confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Certification

\_\_\_\_\_  
Date