Consent for Dental Procedure and Acknowledgement of Receipt of Information

Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it.

I hereby authorize and direct any Colorado licensed dentist working for Comfort Kids Pediatric Dentistry, assisted by other dentists and/or auxiliaries as needed, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable radiographs (x-rays) or diagnostic aids.

In general terms the dental procedure(s) may include:

Cleaning

Fluoride

Sealants
(protective resin application to the grooves of molar teeth)

Nitrous oxide and oxygen
(this gas is utilized to help the child become relaxed during the procedure. The child does not become unconscious)

Treatment of decayed or injured teeth may include:

Local Anesthesia

Silver Fillings

Tooth-Colored Fillings

Stainless Steel Crowns

Tooth-Colored Crowns
(For front teeth only)

Extraction
(removal of 1 or more teeth)

Nerve Treatment

Space Maintainer
(replacement of missing teeth with a "space holder")

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages 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 as expressed or implied either as to the results of the treatment or as to cure. I further authorize the doctor to perform other dental sevice(s) that in his judgement are advisable for my child or legal ward, with the exception of (if none so state):

☐ None ☐ Exception _____

Although their occurrence is extremely remote, some risks are known to be associated with dental or oral surgery procedures including anesthesia or sedation. State Law requires us to mention the risks of numbness, infection, swelling, bleeding, discoloraton, nausea, vomiting, allergic reactions, brain damage, quadriplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures. I further understand and accept that complicaitons may require hospitalizaiton and may even result in death.

I authorize the use of photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

I have read and understand this consent, and all my questions about the procedure(s) have been answered to my satisfaction. I understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

Child's Name _____ **Date** _____ **Time** _____**am/pm**

Signature of Parent or Guardian _____ **Relationship to Patient** _____

Witness or Interpreter _____

I have explained the above to the parent or legal guardian _____