Consent For Dental Treatment

Please read this form carefully and ask about anything that you do not understand. We will be happy to explain it.

- **I hereby authorize Dr. Dora Lee assisted by staff to perform upon my child or legal ward, dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.**

- In general terms the dental procedure(s) may include: cleaning of teeth and application of topical fluoride, application of “sealants”, treatment of diseased or injured teeth with dental restoration (filling or crowns), removal (extraction) of one or more teeth, treatment of malposed (crooked) teeth and/or oral development or growth abnormalities, use of sedative nitrous oxide/oxygen if needed to assist in a more pleasant dental treatment.

- Although their occurrence is infrequent, some risks and complications are known to be associated with dental or oral surgery procedures including anesthesia or sedation. These risks include, but are not limited to: nausea, vomiting, allergic reactions, infection, swelling, bleeding, tissue discoloration, permanent tissue numbness, biting and injuring tongue/lip/cheek following administration of local anesthesia, prolonged bleeding, swallowing or aspiration of a crown form/ an extracted tooth/ gauze packing, damage to and possible loss of existing teeth and / or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. I further understand and accept that complications may require hospitalization, and could result in brain damage, quadriplegia, and death.

- I hereby state that I have read and understand this consent and that all questions have been answered in a satisfactory manner, and 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.

- I further understand that this consent will remain in effect until such time that I choose to terminate it.

______________________________________ _______________
Signature of Parent or Guardian Date

______________________________________ _______________
Signature of Dentist or Staff Date