CORNERSTONE DENTAL ASSOCIATES

The Center for Oral Health

Request and Consent for General Treatment – Child

I request and authorize the dentist and his/her choice of assistant and hygienist to perform my child's treatment plan. I have had the opportunity to discuss with the Doctor my child's medical history indicating any serious problems, injuries, or allergies. I have had explained to me and have had sufficient opportunity to discuss my child's dental conditions, planned procedures and treatments, and the benefits to be reasonably expected from this treatment compared with alternative approaches and no treatment.

I request and authorize the taking of oral-dental x-rays as may be considered necessary or advisable by the dentist to diagnose and treat my child's dental problem.

I understand that antibiotics, analgesics, and other medications can cause drowsiness, lack of coordination, nausea, redness, swelling of tissues, pain, and itching, vomiting, and there may be a possibility of a severe allergic reaction known as anaphylactic shock. Local anesthesia can cause a tingling sensation in the lip, chin, tongue, cheek, teeth or gums that could be temporary or permanent. If any of these symptoms occur, I will contact the doctor's office immediately. It is also not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may administer or prescribe. Alcohol may also increase these effects. Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other additional contraceptive measures be taken during the time of administration.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures. I give permission to make any changes and additions necessary.

I understand that some dental procedures may cause changes in occlusion (biting), jaw or muscle cramps, spasms, difficulty with the jaw, referred pain to the ear and/or neck. I understand that there is always a possibility of delayed healing and/or treatment failure. I give permission for the doctor to make changes and adjustments necessary.

The usual and most frequent risks or complications include, but are not limited to, the possibility of pain or discomfort during and following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a transient or permanent temporomandibular (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

I understand that treatment for my child may include efforts to guide behavior. Should your child become uncooperative during dental procedures the assistant may hold your child's hands, stabilize the head and/or control leg movements. Should major behavioral issues arise the child may be referred to a specialist for treatment with sedation.

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All of my questions have been answered to my satisfaction and I consent to general treatment.

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Signature of Person Consenting to Treatment ***Date***

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Signature of Dentist ***Date***