True Dental Group

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Pediatric Informed Consent

Informed consent indicated 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 a True Dental Doctor assisted by other dentists and/or auxiliaries of their choice, to perform upon my child (or legal ward) the following dental 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
-X-Rays
-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	Extraction (removal of 1 or more teeth)
Silver Fillings	Nerve Treatment
Tooth-colored fillings	Space maintainer (replacement of missing teeth with a "space holder"
Stainless Steel Crowns	Tooth-colored Crowns (for front teeth only)

This treatment has been explained to me. Alternate methods if 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 or the treatment or as to cure.

Although their occurrence is extremely remote, some risks are known to be associated with dental or oral surgery procedures including anesthesia. State law requires us to mention the risks of numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, or allergic reactions associated with such procedure(s).

I authorize the use of photographs, radiographs, other diagnostic materials and treatment records for the purposes of diagnosing and if requested by my insurance company.

I have read and understand that 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.

Patient Name _____ Date_____

Signature of Parent or Guardian _____

Relationship to Patient _____ Witness _____

Responsible Party

True Dental understands there are times a parent or guardian is unable to bring a child in for scheduled appointments or emergencies. As we require parental authorization to care for your child, we ask that you list any family members or other persons who may be informed or participate in your child's care. Appropriate identification in the form of picture ID will be required from the accompanying adult in the absence of a parent.

Name: _____ Relationship_____ Phone# _____

Name: _____ Relationship_____ Phone# _____

Name: _____ Relationship_____ Phone# _____

Name: _____ Relationship_____ Phone# _____

Name: _____ Relationship_____ Phone# _____

By signing, I acknowledge that the above named parties are allowed to bring my child to appointments, have the power to consent to treatment changes at those appointments, and will be held responsible for any estimated co-payments at the time the service is performed.

Patient Name: _____

Parent/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

Parent/Guardian Initials: _____ Child's Name:_____ Date:_____