PEDIATRIC CONSENT TO PERFORM DENTISTRY

Patient's Name:	DOB:	MRN:

I hereby authorize and direct Elica Health Centers (EHC) dentists and dental auxiliaries of their choice, to perform upon my child (or legal ward) the following dental treatments:

- The use of any necessary radiographs (x-rays), intraoral photos, or diagnostic aids for oral examination
- Cleaning of teeth, topical fluoride treatment, dental sealants, dental restorations, dental prosthesis, oral surgery procedure(s), treatment of hard and/or soft tissues, application of caries arresting medicament, and specialty referrals.

I understand that there are risks involved in these treatments. The risks, treatment, alternate treatment methods, if any, and advantages and disadvantages have been explained to me. I had the opportunity to ask questions regarding the treatment and the risks and I fully understand the same.

I agree with the use of advisable local anesthesia and nitrous oxide/analgesia performed on my child (or legal ward). I understand and have been informed that there are possible risks and complications associated with administering local anesthesia and nitrous oxide analgesia. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping or breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

I understand that though good results are expected, the possibility of complications cannot be accurately anticipated and there can be no guarantee either expressed or implied as to the treatment results or the cure. And during treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I authorize and request the performance of any additional procedures deemed necessary or desirable to my oral health and well-being in the professional judgment of the dentists of EHC.

I am aware that it may be difficult to perform dental treatment on a child due to the lack of cooperation which is common in very young children, who are immature, have physical and/or mental handicaps, and are fearful, and/or anxious. I hereby authorize the use of a mouth prop and the assistance of a dental auxiliary in holding the child, if, in the doctor's opinion, the child needs to be restrained during treatment for his/her safety.

CONSENT

I have been informed of the risks and benefits of the proposed treatment. I have been informed of the material risks and benefits of both alternative treatment and of electing not to treat my condition. I authorize and direct this dentist to do what he/she deems necessary and advisable. I consent to the treatment mentioned earlier.

I acknowledge that I have received from Elica Health Centers a copy of the **Dental Material Fact Sheet.**

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND ALL MY QUESTIONS WERE ANSWERED.

Patient/Legal Guardian Name: _____ Relationship to Patient: _____

Patient/Legal Guardian Signature: _____ Date:_____

Provider/Dentist Signature:_____ Date:_____

Witness/Translator Signature:_____ Date:_____