"Healing with Heart"
Elica Health Centers

Pediatric Consent to Perform Dentistry

Patient Name: _____ Date of Birth: _____ Chart#:_____

I hereby authorize and direct the dentists of Elica Health Centers and/or dental auxiliaries of his/her choice, 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 local anesthesia, radiographs (x-rays) or diagnostic aids.

- Cleaning of teeth and the application of topical fluoride.
- Application of plastic "sealants" to the grooves of the teeth.
- Treatment of diseased or injured teeth with dental restorations (fillings).
- Replacement of missing teeth with dental prosthesis.
- Removal (extraction) of one or more teeth.
- Treatment of diseased or injured oral tissue (hard and/or soft)
- Postponing or delaying treatment at this time.
- Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

I understand that there are risks involved in this treatment and hereby acknowledge that these risks have been explained to me, that have had an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages and risks 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 either expressed or implied, as to the results of the treatment or as to the cure.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorized and request the performance of any additional procedures that are deemed necessary or desirable to the child's oral health and wellbeing in the professional judgement of the dentists of EHC.

I agree to the use of local anesthesia and have been informed that there are possible risks and complications associated with the administration of local anesthesia. The most common of these being 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 am aware that it is sometimes extremely difficult to perform dental treatment on a child because of lack of cooperation. This is fairly common in very young and immature children, in those children with physical and/or mental handicaps which diminish their ability to cooperate fully with the procedures and in children who are fearful 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.

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

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

Parent/Legal Guardian Signature: _____ Date: _____

Provider/Dentist Signature: _____ Date: _____

Witness/Translator Signature: _____ Date: _____