Pacific Dental Care, PC

PEDIATRIC DENTISTRY CONSENT FOR DENTAL TREATMENT

It is the policy of the dental practice to inform parents/legal guardians of all procedures performed on your child. At each new patient or periodic appointment, we will identify any treatment needed and discuss with you and your child. Our examination visit consists of an examination of the teeth, soft tissue and bite, radiograph (X-rays) if needed, of oral hygiene instructions, teeth cleaning, and topical fluoride. Any other treatments needed such as sealants, fillings, caps, extractions, space maintainer will mostly be performed at a separate appointment after obtaining your permission.

State law REQUIRES that we obtain your informed consent for any treatment given to your child as a legal minor.

1. I hereby authorize the doctors assisted by their assistants, to perform upon my child the dental treatments as explained in the treatment plan
2. In general terms of dental treatment may include:
   a) Cleaning teeth and applying topical fluoride
   b) Application of sealants to the grooves of teeth to protect
   c) Treatment of diseased or injured teeth with restorations (fillings or caps/ crowns). Front teeth are normally filled with white resin materials and silver materials for back teeth.
   d) Extraction of primary teeth with mobility, or delay exfoliation, and permanent teeth with caries lesion that is non- restorable
   e) Root canal treatment in time where teeth are infected, but too early to have it removed
   f) Placement of space maintainers to retain space for future teeth eruption
   g) Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 2-3 hours. Please remind your child not to bite on his/ her lip while being numbed.
   h) Any treatment of Orthodontics/ braces or referral will be discussed with you separately with referral information
   i) If your child needs nitrous oxide (laughing gas) or any sedation due to anxiety or extensive amount of problem, we will give you a referral to a specialist to proper care for your child.
   j) I fully understand with any surgical procedure, there is a slight chance of surgical or medical complication during or after the procedures. The risks and side effects may include adverse reaction to anesthetic or materials that may cause necessary hospitalization, further surgical procedures, and temporary or permanent nerve damage.

I authorize the doctors at Pacific Dental Care, PC to perform treatment as may be advised to preserve the dental health and life of my child. I have the right to have questions which may arise during treatment. **I also authorize my family members to chaperone my child to the appointments in the event I cannot attend.**

Name of patient:_____

Name of parent/Guardian:_____

Signature:_____ Date: _____