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# Treatment Consent for a Minor

State Law requires us to obtain your consent for your child's contemplated dental treatment. Please read this form carefully, and feel free to ask us if we can explain anything more clearly.

I hereby authorize the doctors, assisted by dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) any and all dental treatment, if needed or recommended.

The doctors have explained the nature and purpose of the treatment and procedures to me in general terms. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages, disadvantages, risks, consequences and probable effectiveness of each, as well as prognosis if no treatment is provided. 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 result of the treatment or as to the cure.

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the application of topical fluoride if it is swallowed and children biting and injuring their tongue or lip following the administration of local anesthesia. For children with heart disease, the risk of subacute bacterial endocarditis (heart infection) following dental treatment exists; therefore antibiotics will be prescribed before the treatment to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment and may require hospitalization.

I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of collaborating with other dental and medical specialists in the care of my child. I further authorize the use of such materials for the purposes of teaching, research, or scientific publications. I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions about the procedure(s) have been answered in a satisfactory manner; and I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I make known that I choose to terminate it. Other: I further authorize the doctors to perform other dental service(s) that in their judgment are advisable for my child or legal ward.

Patient's name: _____

Parent/Guardian's Name: _____

Signature of Parent/Guardian: _____

Date: _____ / _____ / _____

Relationship to Patient: _____