CAMINO HEALTH CENTER

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and sign the section at the bottom of this page.

Patient Name: _____

{ **1. WORK TO BE DONE**

I understand that my child is having the following work done: Fillings: _____ Crowns: _____ Extractions: _____ Root Canals: _____ Pulpotomies: _____ Space maintainers: _____ Impacted teeth removed: _____

Other: _____ (Initials: _____)

{ **2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

(Initials: _____)

{ **3. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials: _____)

{ **4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns) and I authorize the Dentist to remove the

Following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in the teeth, lips, tongue and surround tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand my child may need further treatment by a specialist or even hospitalization if complications arise during or following threatment, the cost of which is my responsibility.

(Initials: _____)

{ **5. ENDODONTIC TREATMENT (ROOT CANAL and PULPOTOMY)**

I realize there is no guarantee that root canal treatment will save my child's tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials:_____)

{ **6. Nitrous Oxide**

I authorize the doctor to administer by nose mask nitrous oxide to my child during his/her dental treatment. Nitrous oxide is used to help my child relax and make him/her less anxious. It is possible that my child may experience nausea as a result of the nitrous oxide.

(Initials :_____)

I understand that dentistry is not an exact science and that, therefore, no practitioner can fully guarantee absolute results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Parent/Guardian: _____ Date: _____