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***A LEGAL GUARDIAN FOR THE CHILD MUST COMPLETE THIS FORM.
REQUEST AND CONSENT FOR DENTAL TREATMENT***

Please read this form carefully. If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it.

1. I request and authorize dental treatment by Dr. Yvette Stokes, Dr. Phillip Caldwell, Associate dentists and staff.

Patient Name: _____

2. I am the Parent/Legal Guardian of the child named above.

3. I further request and authorize the taking of dental x-rays and the use of such anesthetics as may be considered necessary to treat my child's dental need(s).

4. I have had explained to me by Dr. Yvette Stokes, Dr. Phillip Caldwell, Associate dentist and/or staff, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approached and/or no treatment.

5. It is possible for any of the following risks or complications to occur. These risks or complications include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

6. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I or my representative will be contacted prior to or at the initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

7. We invite you to stay with your child during the initial examination. During future appointments, we will have your child accompany our staff through the dental experience. We can usually establish a closer rapport with them if you are not present. Our purpose is to gain your child's confidence and overcome apprehension. However, we may at times invite you to come to the treatment room. During sedation appointments, we do not allow parents in the treatment area due to safety concerns.

OVER PLEASE!

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8. I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and or doctor to hold the patient's hands, stabilize the head and/or control leg movements for their safety. I also understand the routine use of "tooth pillows" (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their mouth that could harm them. I also understand that mouth props are sometimes necessary if the child refuses to open their mouth.

9. I understand that it is not an uncommon response for children to cry before or during dental treatment or directly afterward when they see their parent. I understand the only way I can guarantee my child will not cry during dental treatment is if I elect to have their treatment completed in the operating room under general anesthesia. I also know conscious sedation is an option for some children.

10. For the purpose of advancing medical- dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

11. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.

12. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

13. **I confirm that I am a legal guardian** to the child referenced on the opposite page. I also confirm that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

Signature of Person Consenting to Treatment

Date

Witness Certification

Date

Do not complete the information below unless requested to do so by doctors or staff of Highland Pediatric Dental. **I give consent for the use of protective immobilization of my child by use of a papoose.** All my questions have been answered concerning this method of immobilization.

Signature of Person Consenting to Treatment

Date