Kids' Community Dental Clinic ~ Informed Consent Childs Name: _____

Health professionals have an obligation to provide prospective patients with information regarding the treatment or procedures recommended. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read below carefully, ask about anything you do not understand and we will explain if needed.

1. Drug & Medications Read & Initial: _____
   I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and/or anaphylactic shock (severe allergic reaction).

2. Changes in treatment plan Initials: _____
   I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to make those changes as necessary.

3. Anesthesia Initials: _____
   I realize the risks involved in receiving a local anesthetic, some of which are: Partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, nerve damage and/or numbness.

4. Removal of Teeth Initials: _____
   Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth/tooth and any others necessary under paragraph #3. I understand removing teeth/tooth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) 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 treatment.

5. Endodontic Treatment (Root Canal) & Pulpotomy Initials: _____
   I realize there is no guarantee, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessary effect the success of the treatment, and that this treatment often requires multiple visits and that serious damage or lose the tooth/teeth involved if we do not complete the prescribed treatment.

6. Periodontal Loss (Gum Tissue and Bone) Initials: _____
   If told that I have this serious condition, I understand it causes gum and bone inflammation or loss and that it can lead to the loss of my child's teeth.

I hereby request and authorize the Dentists, Dental Hygienists, DA's and their volunteers, to perform dental work for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues as explained above. The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist and Assistants to perform any other procedures which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encouraged during the operation. I know that the practice of Dentistry and surgery is not an exact science and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein request and authorized. Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage, and/or bleeding, scarring, contraction, possible deformations, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia) fractured jaw, have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THERE IN REFERRED TO WERE MADE AND ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: _____ Date: _____

Parent or Guardian **Rev. 8/2015**