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. 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 (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 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 (paresthesia) 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

Kids' Community Dental Clinic

Acknowledgement form for cancelled or failed appointments

I understand that it is my responsibility to keep my child's appointment and will pay a service fee at the time of each child's appointment ($25). I also understand that I cannot rely on the clinic to remind me of my appointment. If I cannot keep the appointment I will notify the clinic within 2 days of the scheduled appointment. If my child has 2 or more failed or cancelled appointments my child will be placed at the end of the waiting list (including orthodontics) and the clinic has the option to charge me for the missed appointments and may refuse to see my child.I also understand that treatment recommended for my child/children must be completed entirely in a timely manner and that I must continue to keep appointments until I am told that the treatment is completed or my child has turned 19 years old. Dental care received at the clinic includes routine preventative dental treatment and if I fail to complete the entire treatment prescribed for my child or if I fail to return for regular routine checkups every 6 months, the clinic has the option to discontinue treatment.

Multiple Family Appointments– We accommodate families and schedule more than one child at the same appointment time but if the family does not bring all of them or they have 1 or more missed or cancelled appointments the clinics policy is that we cannot schedule multiple family appointments anymore.

I have read and understand the information above and I agreewith these clinic policies.

_____ Date _____

Parent's Signature

Dental Materials Fact Sheet & Notice of Privacy Practices

I have received a copy of the Dental Materials Fact Sheet and Notice of Privacy Practices.

I can ask question about materials used at anytime.

_____ Date _____

Parent's Signature

Parental permission for Photo/Film/PR/Publicity - **AUTHORIZATION TO USE PHOTOGRAPHS AND/OR AUDIO-VISUAL**

I, _____, parent or guardian of _____, hereby authorize the Kids' Community Dental Clinic to use, reproduce, and/or publish photographs and/or video that may pertain to me—including my image, likeness and/or voice without compensation. I understand that this material may be used in various publications, public affairs releases, recruitmentmaterials, broadcast public service advertising (PSAs) or for other related endeavors.

This material may also appear on the Kids' Community Dental Clinic's Internet Web Page. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, the Kids' Community Dental Clinic may publish materials, use my name, photograph, and/or make reference to me in any manner that the Kids' Community Dental Clinic deems appropriate in order to promote/publicize service opportunities.

Description of Material (Photos/Audio-Visual): Annual Update / Annual Report

Video and still images including first name, age, oral health condition, outcome

_____ Date _____

Parent's Signature