

CONSENT FOR DENTAL TREATMENT

TO THE PARENT: You have the right as a parent, to be informed about your child's condition and the recommendation surgical, medical, or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

With regard to my child, _____ I, _____
(Patient's Name) (Parent or Legal Guardian)

voluntarily request Dr. Kenneth C. Thompson and the dental staff of East Texas Children's Dentistry, P.A., to treat my child's condition, which has been explained to me.

I understand and consent to treatment planned for my child which may include:

- Cleaning of the teeth and the application of topical fluoride
- Application of plastic "sealants" to the grooves of teeth
- Treatment of diseased or injured teeth with dental restorations (including silver and tooth colored fillings, stainless steel crowns, and nerve treatment)
- Removal (extraction) of one or more primary and/or permanent teeth
- Replacement of missing teeth with dental prosthesis
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
- Any other procedure, including but not limited to x-rays and use of local anesthetics deemed necessary or advisable to the planned treatment

I understand that all efforts will be made to obtain the cooperation of my child by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. I further understand and consent to the use of behavior management techniques to eliminate disruptive behavior or prevent my child from causing injury to themselves or the staff due to uncontrollable movements in order to facilitate the rendering of necessary dental treatment including but not limited to various forms of physical restraint and nitrous oxide with oxygen (laughing gas). If I wish any exception(s) I have so noted as follows: (if you wish no exception, please write "NONE") _____.

Alternate forms of treatment, as well as the option of no treatment, have been explained to me with the advantages, disadvantages, and risks of each. I have been 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 as to the result or as to cure.

Although their occurrence is extremely rare, some risks are known to be associated with the proposed sedative drugs including but not limited to: nausea, vomiting, allergic reaction, breathing problems, brain damage, stroke, heart attack, and paralysis, the loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures. I further understand and accept that though unlikely, complications may require hospitalization and may even result in death.

- I hereby state that I have read and understand this consent, that I have been given an opportunity to ask any questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner.
- I further understand that this consent will remain in effect until such time that I terminate in writing.
- I understand that although my consent has been given to the above treatment, I will be informed of specific treatment needed prior to treatment being performed.

Signature of Parent or Legal Guardian _____

Signature of Witness _____

Date _____

I certify that the above procedures have been explained to the parent or guardian.

Kenneth C. Thompson, DDS