Informed Consent for Dental Procedures

Please read this form carefully and ask about anything you do not understand. I hereby authorize and direct the pediatric dentists and all dental auxiliaries of Dr. Camps Pediatric Dental Center, to perform upon my child (or legal ward for whom I am empowered to consent) the following dental treatment or oral surgery procedures.

In general terms the dental treatment or procedures will include:

- Examination and radiographs (x-rays) as determined by the dentist.
- Cleaning of the teeth and application of topical fluoride.
- Application of plastic "sealants" to the fissures or grooves of the teeth.
- Administration of local anesthetics to number the teeth and tissues.
- Treatment of diseased or injured teeth with dental restorations or nerve treatments (fillings, crowns, pulpotomies).
- Removal (extractions) of one or more teeth.
- Treatment of diseased or injured oral tissues (hard and/or soft).
- Replacement of missing teeth with space maintainers and/or dental prosthesis.
- Use of patient behavior management techniques to help safely accomplish the necessary dental procedure.

This treatment has been explained to me. Alternate methods of treatment, if any have also been explained to me, as have the advantages and disadvantages and risks of each.

_____

Patient Name

_____ _____ _____

Printed Name of Guardian **Signature of Guardian** **Date**

_____ _____

Signature of Witness **Date**