CONSENT TO PERFORM DENTISTRY

I authorize the dentists at The Kids Dentist LLC to perform upon my child (or legal ward) those procedures as may be deemed necessary or advisable to maintain my child's dental health or the dental health of any minor(s) or other individual(s) for which I have responsibility, now and in the future, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I have been given a dental treatment plan and understand that ignoring a known dental problem has an even greater risk to my child's general health. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

I agree to the use of local anesthesia, if required, on the recommendation of the doctor. I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia. I can ask for an explanation of possible risk and benefits.

I understand that as part of the dental treatment which includes preventative procedures such as cleanings and basic dentistry, and fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of the treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment, items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and in very rare cases, require bronchoscopy or other procedures to ensure safe removal. I understand that this situation is unusual but a possible risk of treatment. I recognize that, during the course of treatment, unexpected circumstances may require additional or different procedures from those discussed. I, therefore, authorize and request the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and wellbeing in the professional judgment of the dentists at The Kids Dentist LLC.

I have been advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all postoperative and post-care instructions be followed, and that the regular office visits, as scheduled by my dentist, must be maintained.

I acknowledge that I am responsible and I hereby agree to pay for services provided to me by The Kids Dentist LLC. I understand payment or estimated portion that insurance does not cover is due at the time of service, unless other arrangements have been made. Any unpaid balances over 90 days from time of treatment will become your financial responsibility. I have disclosed all insurance programs that my child is enrolled in on the registration forms.

All cancelled appointments require 24 hour notice. Failure to contact our office to move or cancel an appointment may result in a missed appointment fee. Two missed appointments within 18 months could be cause for termination of the patient/dentist relationship.

I hereby state that I have read and understand this consent, and I have been given the opportunity to ask questions. All questions about the procedure have been answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during the course of my child's treatment.

Parent Signature:_____

Name of Parent/Guardian: _____ Date:_____

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