Consent for Pediatric Dental Treatment
Amy K. DeYoung, D.D.S., M.S., P.C.

Please read this form *carefully*! If you do not understand something to your satisfaction, please ask questions. We will be happy to explain it!

1. I request and authorize the treatment and procedures outlined on the Treatment Plan for:
   Patient Name: _____

2. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).

3. I have had explained to me by Dr. DeYoung and/or her staff, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from treatment, compared with alternative approaches and/or no treatment.

4. The usual and most frequent risks or complications occurring from treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, bleeding, and injury to adjacent teeth and surrounding tissues. Although very rare, infection, allergic reactions, temporary or permanent numbness or temporomandibular joint disorders are also possible.

5. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's Treatment Plan and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in Dr. DeYoung's office.

6. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and volume.

7. **I understand** that nitrous oxide analgesia may be used in the treatment of my child in addition to any local anesthesia (numbing agent) or other premedication (if any) prescribed by Dr. DeYoung

8. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be ***safely*** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements. This does not constitute holding the child down. Our office will always request your permission before any methods of restraint are used.

9. **I further understand** that should the patient become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a "huggy blanket" or "papoose board" to prevent injury and enable Dr. DeYoung to ***safely*** provide the necessary treatment. In the event that this becomes necessary, you will be notified by Dr. DeYoung or one of our dental assistants prior to its use.

10. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

11. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the Treatment Plan.

12. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

My signature below indicated that I have read (or have had read to me) all of the above information and give my permission for Dr. DeYoung and her staff to treat my child.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Signature of Dr. DeYoung Date

_____ _____

Witness Date