Dental Consent and Authorization Form

Dental Consent to Treatment

I hereby grant permission for Great Mines Health Center (GMHC) and/or other affiliated dentists or dental auxiliaries of GMHC to perform those procedures and treatments deemed necessary or advisable for complete care of a dependent for whom I am legally responsible. Unforeseen circumstances or conditions may require a departure from the original proposed treatment plan. I authorize any Great Mines Health Center licensed provider, and/or dental auxiliary, to perform comprehensive dental care to include but not limited to the following:

Procedures: dental Radiographs (x-rays), examinations and diagnosis, dental prophylaxis (cleaning), and topical fluoride, application of sealants to the grooves of the teeth, Use of local anesthesia to numb the teeth and tissues, treatment of diseased or injured teeth with dental restorations (fillings): Composite Resin (white fillings), Amalgam (silver fillings), Stainless Steel Crowns, Pulpal Treatment (nerve involvement), treatment of injured or infected pulps (nerve) of teeth, removal (Extraction of teeth), Primary (Baby), Permanent (Adult), replacement of missing teeth with dental prosthesis, treatment of diseased or injured oral tissues (hard and soft), treatment of malposed (crooked) teeth and/or oral developmental and growth abnormalities.). Nitrous Oxide/Oxygen (commonly called laughing gas) to alleviate anxiety during dental treatment.

Safety - Physical restraint or restraining devices will be used only when necessary to safely accomplish the dental procedure(s). Physical restraint will consist of: Holding hands and head still, and/or Blanket Wrap and/or Pillow Case (arms).

List any exception:_____

Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated; therefore, there can be no guarantee expressed or implied either as to the result of the treatment or as to the cure.

Risk - Although occurrence are not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complication associated with pediatric dental treatment is nausea following anesthesia. Less common complications to local anesthetics are: prolonged of permanent numbness of the cheeks, lips, tongue, or gums, allergic reaction, rapid heart rate, or a reaction with other drugs they are taking. There is a possibility that the patient might bite the inside of the mouth or tongue before the local anesthetic wears off. The child must be instructed not to do so. Less common treatment complications are: numbness, infection, swelling, prolonged bleeding, tooth discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form or extracted tooth or gauze packing, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root, which may require additional surgery for its removal. I further understand and accept that complications may occur and may require additional medical, dental or surgical treatment, and hospitalization. After treatment, your child may experience pain and swelling. Although child is usually alert and awake upon leaving the office, if Nitrous oxide (laughing gas) is administered, there are rare instances of lingering sedation.

If I do not remain in the dental office while my child is receiving treatment, I am leaving the treatment up to the doctor's judgment and experience, understanding that other treatment may be necessary. If contact with me is not successful, the doctor and GMHC staff have my permission to perform procedures and treatment deemed necessary or advisable.

I have read and understand this informed consent form. I have had an opportunity to ask any questions I might have, and all of my questions, about the procedures, have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I understand that during the course of the planned procedure(s), unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those contemplated. I understand that I am free to withdraw my consent to treatment, with written notice, at any time and that this consent will remain in effect until I choose to terminate it.

Patient's Name: _____Date of Birth_____

Signature of Parent or Guardian: _____

Name and Relationship to Patient: _____Date_____

Office Staff Only_____

Witness:_____ Date_____

I certify that I explained the above procedures to the parent or legal guardian before requesting his or her signature.

Revised 8/6/19