Consent for Treatment

I request and authorize My Kids' Dentists to examine, clean, and provide any necessary dental treatment for:

_____ _____

Patient's Name Date

1) I authorize the use of digital X-rays as may be considered necessary to diagnose and/or treat my child's dental needs. I further authorize the use of anesthetics as may be considered necessary to treat the dental problem(s). I understand there are possible complications/risks associated with Nitrous Oxide that may include, but are not limited to a tingling sensation or a feeling of heaviness, laughter or giddiness, a floating sensation or a feeling of nausea, vomiting or agitation.
2) 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 Treatment Plan and that I will be consulted prior to initiation or treatment procedures not lists. 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 at My Kids' Dentists.
3) I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate to their age. We will provide an environment likely to help children learn to cooperate during treatment using a variety of techniques including praise, explanation and demonstration of procedures and instruments, and variable voice control and loudness.
4) 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 to hold the patient's hands, stabilize the head and/or control leg movements. I further understand that should the patient become combative or uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a "huggy blanket" or "papoose" to prevent injury and enable the Dentist to safely provide the necessary treatment. Should the use of a "huggy blanket" or "papoose" be necessary to complete treatment, I understand that I will be consulted prior to use and be asked to sign a form providing consent.
5) 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.

_____ _____

Print Name of Consenting Parent/Guardian Signature of Consenting Parent/Guardian

_____ _____

Witness Date