My Kids' Dentists Treatment Consent

I 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 radiographs 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 necessary to treat the dental problem(s). I understand there are possible complications/risks associated with **Nitrous Oxide (laughing gas)** 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 signed Treatment Plan and that I will be consulted prior to initiation or treatment procedures not on the list and asked to sign a new Treatment Plan. 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.

3) I understand that dental treatment for children include efforts to guide their behavior by helping them understand the treatment in terms appropriate to their age. We will provide an environment designed to aid children to learn to cooperate during treatment using a variety of techniques including praise, explanation and demonstration of procedures and instruments (tell, show, do), and variable voice control if deemed necessary.

4) I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, this creates a situation in which dental treatment cannot be safely provided. During such disruptive behavior which could cause harm to the patient or the dentist and/or assistant, 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 continue to be combative or uncooperative during dental treatment with excessive body movements, the patient may need to be wrapped in a **papoose** to prevent injury and enable the dentist to safely provide the necessary treatment. Should the use of the papoose be necessary to complete treatment, I will be consulted **prior** to the 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 (Staff) **Date**

My Kids' Dentists 205 Hawkins Store Rd, Suite 100 Kennesaw, GA 30144 770-926-3400