BURBANK
kids dental

CONSENT FOR DENTAL TREATMENT UNDER ANESTHESIA

I authorize Burbank Kids Dental Doctor to perform the following operation or procedure: full mouth dental rehabilitation including, but not limited to:

X-rays	**Sealants**	**Silver fillings**	**White fillings**
Yes ___	Yes ___	Yes___	Yes ___
No ___	No ___	No___	No ___

Silver crowns	**White crowns**	**Root Canals (Pulpotomy)**
Yes ___	Yes ___	Yes ___
No ___	No ___	No ___

Extractions	**Space Maintainers**	**Cleaning**	**Fluoride**
Yes ___	Yes ___	Yes___	Yes ___
No ___	No ___	No___	No ___

I understand the reason for the procedure or operation is: to eliminate cavities and/or infections caused by dental disease. Alternatives to this operation or procedure have been fully discussed with me by the dentist named above. **Initial** _____

Risks: I give this authorization with the understanding that any operation or procedure may involve certain risks or hazards. I understand that such risks include, but are not limited to: infection, bleeding, nerve injury, blood clots, allergic reactions and pneumonia. These risks may imply serious, possibly fatal consequences. The major significant risks of this particular procedure include: pain, bleeding, infection and fever. **Initial** _____

Anesthesia: I understand that administration of anesthesia also involves risks, most importantly a reaction to medications causing death. I understand that such reactions are rare, but the possibility exists. I consent to the use of such anesthetics as may be considered necessary by the person responsible for administration of these medications or anesthetics. I understand these and other risks related to the giving of anesthetics will be discussed with me by the anesthesiologist. **Initial** _____

Additional Procedures: If my physician/dentist discovers a different unsuspected condition at the time of surgery, I authorize him/her to perform such operation or procedure that he/she deems necessary **Initial** ____

Parent's Name:_____ Relationship to Child: _____

Child's Name:_____ Date: _____

Signature: _____

Physician/Dentist Declaration: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge I feel the patient has been adequately informed and has consented to the procedure detailed above.