BURBANK
kids dental

## TREATMENT CONSENT

I understand that by signing below I am requesting and authorizing the procedure(s) to be performed on my child and I have read and understand the possible risks and complications of the procedure(s). The Dentist has reviewed all the treatment options with me and all my questions have been answered.

**Filing:** **I authorize The Doctor to fill teeth #(s): _____**

- ☐ **Yes**
- ☐ **No**

and any others deemed necessary by the Dentist during the course of treatment. I understand that care must be exercised in chewing with fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after- effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed at additional charge, even though the tooth may not have hurt prior to the filling being placed.

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**Pulpotomy/Root Canals/ Endodontic Treatment** **I authorize The Doctor to treat teeth #(s): _____**

- ☐ **Yes**
- ☐ **No**

and any others deemed necessary by the Dentist during the course of treatment. I understand there is no guarantee that Pulpotomy treatment will save my child's tooth, and that complications can occur from the treatment: root canal filling material can extend through the tooth (which will not necessarily affect the success of the treatment) and endodontic files and instruments can separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment and that such additional treatment will be at additional charge to me.

**Crowns:** **I authorize The Doctor to fill teeth #(s): _____**

☐ **Yes**
☐ **No**

and any others deemed necessary by the Dentist during the course of treatment. When a tooth is damaged by decay and a filling will not be effective, a crown may be placed. Pedo crowns can be silver or white in color. I understand that sometimes it is not possible to match the color of artificial teeth to that of my child's natural teeth. I realize the last opportunity to make changes to my child's crown is before permanent cementation. I also understand that after placement of a temporary or permanent restoration, my child's tooth may be temporarily sore or uncomfortable. Occasionally the pulp (nerve tissue) may be irritated by the preparation process or from prior trauma or decay. This may make the tooth extremely sensitive. I understand that, if this persists, root canal or extraction therapy may be necessary at an additional charge.

**Local Anesthesia**
In connection with my child's dental work, local anesthetic may be used. Local anesthesia is commonly used during dental treatment and complications are rare but do at times occur. Risks that can be associated with local anesthesia include dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or additional medical management or hospitalization. In addition, my child may experience restricted mouth opening during recovery, sometimes related to muscle soreness at the site of the injection requiring physical therapy. Local anesthesia may cause prolonged numbness that in some patients may result in injury from biting or chewing an area (lip, cheek or tongue) that has received the local anesthesia. Local anesthesia can cause injury to nerves that can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gum, or tongue which may persist for several weeks, months, or, in rare cases, may be permanent. Local anesthesia is administered with a very fine needle. In rare instances these needles may break off or separate from the hub and become lodged in soft tissue.

**Changes in Treatment Plan**
I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/or all changes and additions as necessary.

**Drugs and Medication**
I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have given the Dentist a complete review of my child's medical history.

The above procedure has been fully explained to me. I consent to treatment of my child as explained above. I understand that there has been no guarantee or assurance made by anyone in regard to the dental treatment I have authorized. By signing below I confirm that I have checked the boxes above and that by checking them I confirm that I have read the foregoing sections and understand the treatment to be undertaken, as well as the risks, benefits, and alternatives and consent to the described treatment. All my questions regarding the above treatment have been answered.

Parent's Name: _____ Relationship to Child: _____

Child's Name: _____ Date: _____

Signature: _____