

**PEDIATRIC DENTISTRY  
CONSENT FOR DENTAL PROCEDURE AND  
ACKNOWLEDGMENT OF RECEIPT OF INFORMATION**

1. State law requires us to obtain your consent to your child's contemplated dental treatment or oral surgery. Please read this form and ask about anything that you do not understand. We will be pleased to explain it. I hereby authorize and direct any Dr(s) of RITA V. PATEL, D.D.S., INC. and/ or dental auxiliaries of his/her choice, to perform upon my child (or legal ward for whom I am empowered to consent) to following checked dental treatment or oral surgery procedures(s).
  
2. In general terms, the dental treatment or procedure(s) will include:
  - a. Radiographs (x rays) of the teeth and jaws.
  - b. Cleaning of the teeth and the application of topical fluoride.
  - c. Application of plastic "sealants" to the grooves of the teeth.
  - d. Use of local anesthesia to numb the teeth and tissue.
  - e. Treatment of disease or injured teeth with dental restorations (fillings and crowns and or pulp treatment).
  - f. Removal (extraction) of one or more teeth.
  - g. Replacement of missing teeth with dental prosthesis.
  - h. Treatment of disease or injured oral tissues (hard and/or soft).
  - i. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
  - j. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedure.
  
3. Although their occurrence is not frequent, some risk and complications are know to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form, an extracted tooth or gauze packing; injury to the tongue and/or lips, 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. For children with heart disease, the risk of subacute bacterial endocarditis (head infection) following dental treatment exists; therefore antibiotics will be prescribed before and following treatment, to minimize the risk.

I hereby state that I have read and understand this consent form, that I have given opportunity to ask questions I might have, and that all questions about the procedures have been answered in a satisfactory manner and I understand further that I have the right to be provide with answers to questions which may arise during the course of my child's treatment. By signing this form I consent and authorize the doctors of RITA V. PATEL, D.D.S., INC. to furnish dental treatment on my child.

Patient's Name: .....

Signature of Parent or Guardian: ..... Date: .....

Relationship to Patient: ..... Witness: .....

Signature of Dentist: ..... Date: .....