Dr. J. Bradford Smith, D.D.S.
Family and Cosmetic Dentistry

PEDIATRIC AND ADOLESCENCE CONSENT FOR DENTAL PROCEDURES

Patient's Full Name: _____ Date of Birth: _____

It is customary of our office to inform parents of all procedures diagnosed for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child in detail. We follow recommendations made by the American Dental Association instead of insurance limitations. Each routine examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, necessary radiographs (x-rays), and examination of the teeth, hard, and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps/crowns, extractions, etc., will be performed at a separate appointment after obtaining your permission.

State law requires that we obtain your written informed consent for any treatment given to your child as a legal minor.

1. I hereby authorize and direct Dr. J. Bradford Smith assisted by dental auxiliaries of his choice, to perform upon my child the following dental treatments or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids, and nitrous oxide.

2. In general terms the dental procedures may include:
    A. Cleaning of the teeth and the application of topical fluoride.
    B. Application of plastic "sealants" to the groves of the teeth.
    C. Treatment of the diseased or injured teeth with dental restorations (fillings or caps/crowns). The caps/crowns are normally white on the front teeth and silver on the back teeth.
    D. Placement of space maintainers.
    E. Treatment of malposed (crooked) teeth and or oral developmental or growth abnormalities.
    F. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1½ to 3 hours. Allergic reactions are rare and your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child they are going to get a "shot", we have a special way of informing them of this that prevents fear.
    G. Use of nitrous oxide (laughing gas) is often used to help children relax and feel the injection less. This gas is placed over your child's nose after an explanation is given. This gas is very safe when used in the concentration that will be used, and the nose piece, as with all treatment, will not be forced upon your child.
    H. I fully understand there is a possibility of surgical and or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death.

I further authorize Dr. J. Bradford Smith to perform treatment as it may be advisable to preserve the health and life of my child. I further understand that parents may be asked to remain in the reception area if needed for behavior management or for the benefit of the success of the treatment. I hereby state that I have read and understand this consent and that all questions about the procedures have been answered in a satisfactory manner. I also understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

_____
Name of Parent/Guardian

_____ _____
Relationship to Patient Signature of Parent/Guardian Date: