Nashville Pediatric Dentistry

Pediatric Dental Consent for Dental Procedures and Acknowledgment of Receipt of Information

Thank you for choosing Nashville Pediatric Dentistry for your child's dental care. We look forward to providing the best care for your child. State law requires us to obtain your consent for your child's proposed dental treatment or oral surgery. Please read this form carefully and ask about anything you do not understand. We will answer all of your questions. By signing this form you as the parent/guardian of your child allow us to provide recommended dental treatment for your child after we *have* discussed all recommended treatment with you.

The following are procedures a pediatric dentist may perform. Any of the following will be explained prior to the specific procedure. You have the right to refuse consent to a procedure before it is performed. In general terms the dental procedure(s) or operation may include:

A. Cleaning of the teeth and the application of dental fluoride.
B. Dental x-rays.
C. Application of sealants to the *grooves* of the teeth.
D. Treatment of diseased or injured teeth with dental restorations.
E. Replacement of missing teeth with dental prosthesis.
F. Removal (extraction) of one or more teeth.
G. Treatment of diseased or injured oral tissues (hard/soft).
H. Treatment of malposed (crooked) teeth, development, or growth abnormalities.

I hereby authorize and direct Dr. Brian Wah, assisted by other dentists and/or dental auxiliaries of his choice, to perform upon my child (or legal ward) the above mentioned dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-ray) or diagnostic aids.

The treatment that is planned for my child has been explained to me. Alternative methods of treatment, if any, have also been explained to me as have the advantages and disadvantages of each. I am advised that, though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the results of the treatment or as to cure. I further authorize the doctor to perform other dental services that, in his judgment, are advisable for my child or legal ward, with the exception of (if none so state):

Although their occurrences are extremely remote, some risks are known to be associated with dental or oral surgery procedures including anesthesia or sedation. State Law requires us to mention the potential risks of numbness including infection, swelling, bleeding, discoloration, scarring, nausea, vomiting, and allergic reactions. I further understand medical complications may arise requiring hospitalization.

I also authorize Dr. Brian Wah to use photographs, radiographs, or other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

I hereby state that I *have* read and understand this consent, and that all questions about the procedure or the procedures have been answered in a satisfactory manner, and I understand that I have the right to be provided with answers to questions which may arise during the course of my child's or legal ward's treatment.

I further understand that this consent will remain in effect until such time I choose to terminate it.

Parent's name _____Date:_____
Signature of Parent or Guardian: _____
Relationship to Patient:_____