Consent or Dental Procedures and Acknowledgement of Receipt of Information

State Law requires us to obtain your consent for your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask questions about anything that you do not understand.

1. I hereby authorize and direct Dr. Georganne McCandless, assisted by other dentists and/or dental auxiliaries of their choice, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aid

2. In general terms the dental procedure(s) or operation will include:

___A. Examination
___B. Cleaning of the teeth and the application of topical fluoride
___C. Dental radiographs (x-rays)
___D. Application of plastic "sealants" to the teeth
___E. Treatment of diseased or injured teeth with dental restoration
___F. Crown
___G. Removal (extraction) of one or more teeth
___H. Pulp (nerve) therapy
___I. Orthodontic Work-Up
___J. Impression for ______________________
___K. Use of sedative drugs to control apprehension and/or disruptive behavior
___L. Nitrous
___M. Use of IV Sedation to accomplish the necessary treatment
___N. Discing
___O. Other_____________________________

This treatment has been explained to me. Alternate 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 therefore there can be no guarantee as expressed or implied either as to the result of the treatment or as the cure. I further authorize the doctor to perform other dental services that, in her judgment, are advisable for my child or legal ward, with the exception of (if none so state):___________________________________

3. Although their occurrence is 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 risks of numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars with such procedure(s). I further understand and accept that complication may require hospitalization and may even result in death.

4. I authorize Dr. Georganne McCandless to use photographs, other diagnostic materials and treatment records for the purposes of teaching, research, and scientific publications.
I hereby state that I have read and understand this consent, and that all questions about the procedure(s) have been answered in a satisfactory manner; and I understand that I have the right to be provided with answers to questions that 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.

Patients Name:_____________________________
Signature of Parent or Guardian:_______________
Relationship to Patient:____________________________ Witness:________________

Signature of Dentist:

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