



Kidcare Dental Office  
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## CONSENT FOR DENTAL TREATMENT

I, \_\_\_\_\_ the parent/guardian of \_\_\_\_\_ do hereby give consent to the following dental procedures to be performed by Dr. Jennifer Ebner and her licensed staff:

I authorize the taking of photographs, x-rays, any other records as is deemed necessary for use by Kidcare Dental Office its doctors and staff, or any entity authorized by Kidcare Dental Office. I acknowledge that all original records and diagnostic aids are the property of Kidcare Dental Office. Copies may be furnished upon written request based on established policies of the office. There may be a fee for duplication and/or transfer of records.

I authorize the evaluation, diagnosis and performance of restorative procedures, oral surgery, orthodontic treatment and/or other dental procedures deemed necessary or advisable by Dr. Ebner including the administration of local anesthesia (i.e. Novocain) and/or nitrous oxide, sedative drugs, and/or physical restraint with the exception of (so state if none)\_\_\_\_\_.

I understand that sedation may be partially or completely ineffective in managing my child. In such instances, the planned treatment may not be possible or may be incomplete and it may take several appointments using sedation techniques and/or alternative methods to complete the necessary treatment in a safe and comfortable manner.

I understand that the doctor and her dental staff will be performing the listed procedures. It has been explained to me that unforeseen conditions may be encountered that require procedures other than those originally diagnosed. I therefore authorize the doctor to perform such additional procedures or treat unhealthy or unforeseen conditions that may be encountered as she may seem necessary or desirable during treatment *after I have been consulted and prior to initiation of treatment procedures not listed.*

I have been informed and understand that occasionally there are complications associated with dental surgery, sedation medications, anesthetic agents including, but not limited to, pain, infection, swelling, bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, allergic reaction to any medications or materials (before, during and after the procedure), numbness (temporary or permanent), itching of the tongue, lip, teeth, tissues (paresthesia), development of a temporomandibular joint disorder, injury to adjacent teeth or surrounding tissue, fractured jaw, vomiting, nausea, amnesia. Rarely, these complications may require hospitalization

The nature and risks of these procedures have been fully explained to me and I understand them. I have had sufficient opportunity to discuss the patient's dental condition/problem(s), the TREATMENT PLAN, sedation and anesthesia procedures, and the benefits to be reasonably expected from these treatments/procedures, compared with alternative approaches and/or no treatment. I recognize that the practice of dentistry is not an exact science and that no guarantees have been made to me concerning the result of these procedures I have requested and authorized. Any efforts to alter the results will be made at the sole discretion of the treating dentist.

Kidcare Dental Office reserves the right to discontinue treatment if, in their sole opinion, circumstances justify such action. Among reasons for discontinuation of treatment are repeated lateness and failure to keep appointments.

All of my questions have been answered to my satisfaction and I consent to treatment and procedures prescribed for the patient listed on the TREATMENT PLAN.

I acknowledge I have received and reviewed the Dental Materials Fact Sheet.

I acknowledge I have received Kidcare Dental Office's Notice of Privacy Practices.

Name of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_