TEXAS Kids DENTAL CARE
9411 Avenue Ste P
El Paso, TX. 79907
Phone: 915 858 6868

PEDIATRIC DENTAL TREATMENT CONSENT FORM

As health professionals, it is necessary that we obtain your consent for dental/oral treatment of your child. Please read this form carefully and ask any questions that may not be clear, or that you may not understand. **This is only to inform you of what type of services we provide, which varies from child to child according to their needs.**

1. I _____ authorized Dr. Erickson and/or his associates and dental assistants to treat my child
(Name of parent or guardian)

for the following dental or oral surgery procedures, including the use of oral anesthesia, intramuscular anesthesia, oral sedatives or radiographs that may be necessary to provide dental treatment.

2. In general terms the above procedures may include:

Please mark your initials:

A. _____ Dental cleaning, fluoride application and radiographs as necessary.
B. _____ Application of sealants.
C. _____ Restoration of broken teeth or fillings.
D. _____ Treatment of infected teeth or gums.
E. _____ Extractions of 1 or more teeth.
F. _____ Use of "voice control" in order to gain attention of children with negative behavior.
G. _____ Use of physical restraints to properly and securely perform necessary dental procedures.
H. _____ Use of local anesthetics.
I. _____ Use of sedative drugs for the control of nervousness or negative behavior.
J. _____ Use of nitrous oxide to help reduce anxiety.
K. _____ Use of oral and intramuscular can lead to deep sedation and general anesthesia and the associated risks of these types of anesthesia.
L. _____ IV Sedation or General Anesthesia. The risks of General Anesthesia include, but are not limited to the following: tenderness, bruising, nausea, vomiting, aspiration, swelling, bleeding, infection, numbness, allergic reaction, stroke, heart attack, and death. Some of these complication may require hospitalization. Serious complications are very rare.
M. _____ Due to the difficult nature of managing the behavior of some children or patients, a complete exam is not always possible on the initial visit. I give permission to Dr. Erickson and his associates to perform any dental treatment they deem necessary and appropriate while my child is sedated and cooperative or under general anesthesia.

My child's treatment, alternative methods of treatment, as well as the advantages and disadvantages of each will be explained to me. We will advise you that although the best results are expected, there is no way within reason of anticipating complications. Therefore, it is not possible to guarantee the results or cure of the treatment.

Although the occurrence is remote, it is known that some risks are associated with dental procedures. We are required to mention the following: bleeding, numbness, infection, damage to central nervous system, reduction or loss of function of internal organs and limbs, as well as disfiguring scars. I understand and accept that certain complications may be fatal or require medical intervention.

_____ Parent or Guardian Signature

_____ Date

_____ Witness