



CONSENT FOR PEDIATRIC DENTAL TREATMENT OF:

Patient Name

It is necessary for us as health professionals to obtain your consent for your child's dental treatment. Please read this document carefully and ask about anything you do not understand.

1. With my written consent, I hereby authorize Dr. Grace Wenham, Dr. Beth Blair, their associates and/or hygienists/assistants to perform upon my child the following dental treatment, including the use of any necessary or advisable local anesthesia, analgesia or radiographs as will be explained to me.

In general terms, the dental procedures may include:

- a. Teeth cleaning, fluoride application and any necessary x-rays
- b. Photographs
- c. Applying plastic "sealants" to the grooves of teeth
- d. Repairing diseased or broken teeth with fillings or crowns
- e. Treating infected teeth and/or gums

*I understand that on some occasions treatment is subject to change once in the dental treatment chair. I authorize any necessary changes to be made by Dr. Grace Wenham, Dr. Beth Blair and/or their associates to do what is in the best interest of my child.

2. Although their occurrence is extremely remote, some risks are known to be associated with dental procedures. These risks include but are not limited to the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness and allergic reaction. Occasionally, a child may also chew/irritate his or her own cheek, lip or tongue while numb. It is the responsibility of the parent/guardian to closely monitor their child to decrease the risk of such complication.
3. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and volume.
4. I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.
5. I understand that should the patient be too young to cooperate or become uncooperative during dental procedures with excessive body movements, the patient may need to be immobilized to prevent injury and enable Dr. Grace Wenham, Dr. Beth Blair and/or their associates to safely provide the necessary treatment. Should the use of immobilization become necessary, you will be asked to sign a separate consent form which will be explained to you at that time.

In general terms, the behavior management techniques during treatment will include:

- a. Tell, Show, Do
- b. Distraction
- c. Positive reinforcement
- d. Use of voice control to gain the attention of a disruptive child
- e. Use of physical restraint to safely accomplish necessary dental procedures. This may include hand and/or head holding

6. I give permission for the following individuals to consent to treatment for my child on my behalf:

Name	Relationship
Name	Relationship
Name	Relationship

7. I confirm that I have read (or it was read to me) and understand the information on this document. I am advised that although good results are expected, the possibility and nature of complications cannot always be accurately anticipated. Therefore, there can be no guarantee as to the result of the treatment.

I understand the treatment proposed and give permission to Dr. Grace Wenham, Dr. Beth Blair and/or their associates to complete any treatment needed and make changes to treatment as needed.

Parent/Guardian Signature	Relationship to Patient
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