GENTLE DENTISTRY
Family and Cosmetic

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CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Gentle Dentistry and/or dental auxiliaries of his/her choice to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s); including the use of any necessary advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
    - Cleaning of the teeth and the application of topical fluoride.
    - Application of plastic "sealants" to the grooves of the teeth.
    - Treatment of diseased or injured teeth with dental restorations (fillings) or crowns (caps).
    - Replacement of missing teeth with dental prosthesis.
    - Removal (extraction) of one or more teeth.
    - Treatment of diseased or injured oral tissues (hard and/or soft).
    - Pulp (nerve) treatment on one or more teeth.
    - The removal (excision) of diseased, inflamed hard and soft tissue tumors or lesions.
    - The placement of sutures for wound closure.
    - The placement of splints or appropriate wound dressings.
    - The repositioning of one or more teeth.
    - Tooth bleaching.

2. I understand that there are risks involved in the treatment and hereby acknowledge that these risks have been explained to me, that I have had an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor(s). I understand that nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure.
    - This treatment has been explained to me. Alternate methods of treatment, if any have also been explained to me, as have the advantages, disadvantages and risks 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 cannot be a guarantee either expressed or implied, as to the result of the treatment or as to the cure.
    - I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well-being in the professional judgement of the dentists of Gentle Dentistry.

4. I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, nitrous oxide, and drugs. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa.

5. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

6. The alternatives to these methods of treatments are:
    - Do not perform the recommended treatment.
    - Referral to a specialty dentist of pediatrics.

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Patient's Printed Date

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Parent/Guardian Signature