# PEDIATRIC DENTISTRY CONSENT FOR DENTAL PROCEDURE AND ACKNOLEDGEMENT 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 about anything that you do not understand. We will be pleased to explain it. After an oral examination and radiographs, Dr. Lodolini or Dr. Bianchi will explain to you what your child's dental needs are. The appropriate treatment plan, available alternatives, and number of appointments needed will be discussed with you.

1. Radiographs
2. Cleaning of teeth and Fluoride treatment
3. Sealants
4. Local anesthesia to numb the teeth and tissues.
5. Treatment of diseased or injured teeth with dental restorations (fillings).
6. Removal of one or more teeth.
7. Treatment of diseased or injured oral tissues (hard and/or soft).
8. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that I am free to withdraw my consent to treatment at any time and that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name: ______________________________________________________________________________

Signature of Parent of Guardian _____________________________ Date: _____________________________

Relationship to Patient ________________________________________________________________________

I certify that I explained the above procedures to the parent or legal guardian before requesting their signature.

______________________________________________          ______________________

Signature of Dentists          Date

TO WHOM MAY WE SEND THANKS FOR REFERRING YOU TO OUR PRACTICE.

NAME: _____________________________________________

ADDRESS: ___________________________________________________________________________________