Consent to Dental Surgical Procedure and Acknowledgement of Receipt of Information

State law requires us to obtain your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and consent for oral and dental radiographic (X-RAY) examination and diagnosis, dental prophylaxis (cleaning) and topical fluoride treatment to be performed upon my child (or legal ward) for whom I am empowered to consent.

I further consent to emergency treatment for _____

Which I understand will include the following: _____

[Informed Consent for Specific Procedures]

I hereby authorize and direct Dr. Gerges Gaid and the dental staff of Cupertino Ortho Care and Kids Dentistry to perform upon _____, my child (or legal ward) the following dental treatment or oral surgery procedures.

- ✓A. Application of sealants to the grooves of the teeth.
- ✓B. Use of local anesthesia to numb the teeth and tissues.
- ✓C. Treatment of diseased or injured teeth with dental restorations (fillings)
  Filling Type: _____

- ✓D. Treatment of injured or infected pulps (nerves) of teeth.
- ✓E. Removal (extraction) of teeth.
  Extraction Type: _____
  Tooth Number: _____

- ✓ F. Replacement of missing teeth with dental prosthesis.
- ✓ G. Treatment of diseased or injured oral tissues (hard and soft).
- ✓ H. Treatment of malposed (crooked) teeth and/or oral development of growth abnormalities.
  Treatment and Condition: _____

- ✓ I. The use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
  Restraint Device(s): _____

- ✓ J. Other.

I understand that during the course of the planned procedure(s), unforeseen conditions may arise that may necessitate treatment or procedures in addition to, of different from those contemplated. Therefore, I further authorize Dr. Gerges Gaid and the dental staff of Cupertino Ortho Care and Kid's Dentistry to perform other dental service(s) that in their judgment are advisable for my child or legal ward, except for:

None.

The nature and purpose of the treatment and procedures have been explained to me in general terms by Dr. Gerges Gaid. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided. I am advised though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee expressed or implied either as to the result of the treatment or as to cure.

[RISKS]

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery and/or diagnosis procedures. The most common complications associated with dental treatment include nausea following anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form, an extracted tooth or gauze packing; injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fractured of a tooth root which may require additional surgery for its removal. I further understand and accept that complications may require additional medical, dental or surgical treatment and may require hospitalization.

Additional risks can include:

[PROPHYLACTIC ANTIBIOTICS]

For children with heart disease, the risk of infective endocarditis (heart infection) following dental treatment exists; therefore antibiotics will be prescribed before and following treatment, to minimize the risk. The current recommendations of the American Heart Association and the American Academy of Pediatric dentistry will be followed as a guide.

[UNDERSTANDING THIS FORM]

I hereby state and that I have read and understand this consent form, that I have been given the 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 force until such time that I choose to revoke it in writing.

Patients Name (For whom consent for treatment is granted): _____

Parent/Legal Guardian
Signature: _____

Relation
To Patient: _____ Date: _____

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

Treating Dentist: _____