DENTAL TREATMENT CONSENT FORM

Work proposed for _____

I understand my child needs the following work done:

___ Fillings

___ Crowns

___ Pulpotomies

___ Space Maintainers

___ Sealants

___ Treatment with Nitrous Oxide (informational sheet given)

___ Extractions

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary.

Removal of Teeth

Alternatives to removal of teeth have been explained to me (pulpectomy, crown) and I authorize the dentist to remove necessary baby teeth. I understand removing of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling or spread of infection.

Parent's Signature _____ Date _____

Doctor's Signature _____