BENTON CITY BRACES

INFORMED CONSENT FOR PEDIATRIC DENTISTRY

As a parent it is your right to understand the risks, benefits, and alternate dental treatment options for your child. You may accept or refuse treatment offered to your child. Please read this form carefully and ask about anything you do not understand.

EXAM

Every child is a unique individual thus not every child will require the same dental treatment. Based upon your child's age, teeth present, and tooth position, the doctor will determine what treatment is necessary. Your child's exam appointment may include a comprehensive exam, fluoride treatment, teeth cleaning, and radiographs (x-rays) if necessary. If you have any questions or concerns about our examination procedures please feel free to discuss this with the doctor or her staff prior to your child's dental visit.

TREATMENT

If your child should need any dental treatment after the dental examination has been completed, the doctor will review the planned treatment with you. Please read the following information regarding dental treatment at our office.

• It is our policy that all treatment options are explained to the parent(s), including treatment alternatives, advantages, and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.

• Risks that are occasionally associated with dental treatment procedures include: numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infection. On rare occasions complications may arise that require hospitalization.

• I agree to remain within the dental office facility where my child is being treated.

I have been advised of the benefits, risks, and possible side effects of proposed treatment, and possible consequences of not receiving the treatment. Treatment alternatives, including no treatment, have been presented to me and all of my questions regarding my child's care have been answered satisfactorily.

PHOTO CONSENT

I authorize Benton City Braces to photograph me or my family for the following purposes .

Posting on Facebook**:** Initial_____.

Posting in office: Initial_____.

Dental records: Initial_____.

Patient(s) Name:_____Date:_____

Parent Name:_____Parent Signature:_____