

Patient ID _____

PATIENT NAME _____

Last

First

DOB

I hereby authorize _____

DOCTORS NAME

and whomever he may designate as his assistant(s), to perform upon my child the following operation and/or procedure:

I request and authorize him to do whatever he deems advisable if any unforeseen conditions arises in the course of these designated operations and/or procedures calling, in his judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the possible risks, advantages and disadvantages of the treatments and the consequences if this treatment was not completed.

I consent to the above treatment after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drug that may be deemed necessary in my child's case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g. allergic reactions) cardiac arrest, and aspiration and thrombophlebitis (e.g. irritation and swelling of a vein) pain, discoloration and injury to blood vessels and nerves which may be caused by injections of medications and drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications in oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, and stiff jaw.

I realize that in spite of the possible complications and risks, my child's contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operations or procedure.

I have provided as accurate and complete medical history as possible including those antibiotics, drugs, medications and food to which my child is allergic or sensitive. I will follow any and all instructions as explained and directed to me in preparation of my child's surgery.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my child's medical conditions, contemplated and alternative treatment and procedures, and the risks and potential complications of the contemplated and alternative treatment and procedures prior to signing this form

Parent of Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

Witness's Signature _____ Date _____