Pediatric Dentistry
Orthodontics
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CONSENT TO CONSCIOUS SEDATION AND TREATMENT

I authorize the treating Doctor and the PDO team to perform upon my child the following procedure(s), and/or treatment:

Dental Restorations including Silver Caps (Stainless Steel Crowns)
Prophylaxis, fluoride treatment
Extractions, space maintainers
Conscious sedation with pediatric restraining wraps and mouth prop

If any conditions are revealed or arise during the course of the operation, procedure, and/or treatment in addition to or different from those now contemplated, I authorize the performance of such procedure or treatment without terminating the initial procedure or treatment to discuss these additional or different procedures or treatments with me.

The nature and purpose of the procedure and/or treatment, the risks involved and the possible complications and side effects, the risk and consequences of no procedure, and/or treatment, and possible alternatives to the procedure, and/or treatment have been fully explained to me. The material risk, complication and possible alternatives are set forth below and have been discussed with me. I acknowledge and understand the results of the treatment, and/or procedure are not guaranteed and that unpredictable complications might arise in addition to those discussed with me.

Alternatives to conscious sedation are restraining the patient, nitrous oxide/oxygen relative analgesia, or IV sedation. Electing not to have treatment is an alternative, but may result in abscesses, damaging permanent teeth, pain, and swelling causing space loss for permanent teeth or serious medical complications.

I authorize the treating Doctor to prescribe and use such sedation agents as they may consider advisable in the procedure. The risks and complications of conscious sedation have been explained to me and the material risks and complications of conscious sedation are listed below. I understand the administration of medications may lead to unpredictable complications in addition to those discussed with me.

I fully understand there is a possibility of surgical and/or medical complications developing during or after procedures. These risk and side effects may include but are not limited to: vomiting, numbness, discoloration, infection, aspiration, allergic reaction, breathing difficulties, or atypical psychological response that may even cause necessary hospitalization, further surgical procedures, disability, and system impairment, nerve damage, brain damage, resulting in falling and subsequent injuries, or death.

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I consent to the medically appropriate disposal of any tissue or teeth which may be removed in the procedure. I consent to the taking and using of any photographs in the course of the procedure for the purpose of advancing medical/dental education, provided that the photographs or any accompanying description does not reveal the patient's identity. For the purpose of advancing medical/dental education, I also consent to the admittance of authorized observers to the procedure.

My signature below certifies that I have:

1. Read and fully understand the above consent
2. This form has been fully explained to me
3. The proposed procedure and/or treatment has been satisfactorily explained to me in a language that I have understood
4. The risks, complications, and alternatives to the procedure have been explained to me in a language that I have understood
5. All my questions have been answered and the explanations referred to in the above paragraphs were discussed with me.
6. **Acknowledge that my child has had NO food or liquids consumed in the last 8 hours.**

_____ _____

Parent/Guardian's Signature Name of patient receiving treatment

_____ _____

Today's Date Witness's Signature