Pediatric Dentistry
Orthodontics
TRUPKIN • WILENTZ • CHIZNER

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

The permission of a parent or legal guardian is necessary for dental treatment of a minor before any treatment can be started or completed by our office. While signing this form gives consent for us to treat your child, we encourage you to speak to any of our staff members, especially the treating Doctor, if you have any questions regarding your child's specific needs or treatment being provided.

Consequences of No Treatment
I have been advised that the consequences of not treating this condition include but are not limited to: Infection, swelling, pain, periodontal disease, malocclusion, fracture of the jaw and/or loss of bone. These complications may cause pain, destroy jawbone and teeth, and adversely affect overall health.

Local Anesthetic (numbing medication)
The treating Doctor will use local anesthetic to help your child feel comfortable during the procedure.

Possible Risks or Complications
I understand that all dental and medical treatment pose foreseen and unforeseen risks. These risks include, but are not limited to, the following:
- Swelling, bleeding, bruising and/or pain after the procedure
- Decision to leave a small piece of root/tooth of the primary or permanent tooth in the jaw when its removal would require extensive surgery or increased risk to nearby teeth or permanent teeth developing under primary tooth
- Possible infection and/or hospitalization and/or referral to a specialist for further treatments
- Injury to nerves in or around the mouth that could cause partial, full temporary, or permanently numb lips, chin, tongue, or loss of taste sensation
- "Dry Socket" or slow healing of an extraction site
- Injury to nearby teeth or fillings
- Sore jaw or restricted mouth opening or TMJ problems (jaw joint may not function well)
- Unusual reaction to medications given or prescribed
- Anesthetic Risk (numbing medication): include discomfort, rapid pulse, swelling, bruising, infection, anxious feelings, allergic reactions, and lip/cheek chewing.

Patient's (Parent/Guardian) Consent
The diagnosis and reason for surgery has been discussed with me, along with any alternatives for treatment. I am aware that the practice of dentistry is not an exact science, that the very nature of the treatment and my child's uniqueness as an individual require that no predictions can be made. I acknowledge that no guarantees have been made to me. I also agree to follow post-operative instructions provided to me by the treating Doctor and/or her staff. I have had the opportunity to ask any questions if I have any.
I have read and fully understand this consent form. I understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction. I also understand that I should not sign this form if I do not understand any of the words contained in this form.

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If Space Maintainer is recommended:

If a baby tooth is lost prematurely, neighboring teeth may shift and create problems for adult teeth trying to come in later. To minimize this problem a space maintainer is used to hold teeth in their correct positions. This is done by placing bands and wire between teeth to hold them apart from one another. This device will be affixed with semi-permanent cement, that may wash out over time. Diligent care must be used to keep the teeth clean from food and plaque which if built up, may lead to decay. Soreness is to be expected after placement of appliance. The maintainer may interfere with soft tissue such as gums, tongue, lips, and may become loose in time, requiring re-seating later on. At times, re-cementing the appliance may not be possible and a new appliance may be required, at which time, any additional fees would be discussed.
My alternative is to not place a space maintainer, while acknowledging drifting of teeth may occur, and crowding problems later on.
By signing the below consent, I understand it is my responsibility to notify this office should any unexpected problems occur or if any problems relating to the treatment rendered are experienced. Routine examinations by the dentist are recommended to allow ongoing assessment of the space-maintainer placed.
I have been given the opportunity to ask questions regarding the nature and purpose of space-maintainer and have received answers to my satisfaction. I voluntarily undergo this treatment in hopes of achieving the desired results from the treatment rendered though no guarantees have been made regarding the outcome. I hereby assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize Pediatric Dentistry and Orthodontics and/or all associates involved in rendering the services or treatment necessary to the existing dental condition.

_____ _____
Parent/Guardian's Signature Name of patient receiving treatment

_____ _____
Today's Date Witness's Signature