AS4U0716 -SPACE MAINTAINER: INFORMED CONSENT FOR DENTAL TREATMENT

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SPACE MAINTAINER: INFORMED CONSENT FOR DENTAL TREATMENT

DOCTOR:

TOOTH #:

LOCAL ANESTHETICS, GENERAL ANESTHETICS AND/OR NITROUS OXIDE
Benefits:
Avoid pain during treatments and procedures.

Possible Complications:
Most risks are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Prolonged numbness, nerve damage, & bruising (hematoma) in rare instances. Possible consequences may include all those applicable to general anesthesia, including cardiovascular, pulmonary or allergic reactions up to & including death.

Consequences of not having done:
Mild to severe pain during & after treatment.

Alternatives:
Willingness to accept pain during treatment.

DIGITAL RADIOGRAPHS
Benefits:
Complete diagnosis, detect hidden problems, & inform treatment decisions. Qualified personnel take digital radiographs.

Possible Complications:
Exposure to digital radiograph radiation (minimal). Digital radiographs remain the property of this office.

Consequences of not having work done or postponing:
Cannot perform dental services.

Alternatives: None

SPACE MAINTAINER:

Benefits:

To maintain a space for the permanent tooth to erupt and move in position.

Possible Complications:
Loosen the appliance by consuming sticky foods or by playing with the appliance with your tongue or fingers.

Consequences of not having work done or postponing: Crowded or misaligned teeth.

Alternatives: None

CHANGES IN TREATMENT:
I understand that during the 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 necessary.

I have read the above statements and have received a copy (if requested), and recognize their importance in helping me with making my decisions. My signature indicates that I have read and understand this consent document.

I recognize that failures can occur for various reasons and complications can occur in any procedure. I hereby grant authority to the doctor in charge to administer such procedures that may be deemed necessary or advisable in the diagnosis and/or treatment. I also certify that the information I submitted in the health questionnaire is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending doctor and me, I will give that doctor the opportunity to resolve the problem.

The risks and benefits associated with the above-referenced dental treatment have been thoroughly explained to me. I understand there is no certainty that I will achieve the desired benefits and/or results, and no guarantee or assurance has been made to me regarding the outcome of such dental treatment. In authorizing the abovereferenced dental treatment to be performed, I understand that unforeseen conditions may occur during such treatment, which may necessitate a total change, extension or modification of the original treatment outlined above, or necessitate a different type of treatment than such authorized treatment set forth above. I therefore authorize and request that such treatment may be necessary and desirable in the exercise of my doctor’s professional judgment.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the extraction(s), I agree to report them to the office as soon as possible. In case of an acute emergency, and in the event you cannot reach this office, or we have not returned your call in a reasonable amount of time, please proceed to the nearest emergency room for medical attention.

Furthermore, I have been fully informed as to the nature of my dental treatment including other such care and treatment, along with the potential benefits, risks or side effects of such dental treatment, and the likelihood of achieving the desired results. I have been told that the success of the dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I have discussed all of the above with the doctor, and have had all of my questions answered to my satisfaction. I consent to treatment.

Signature of Patient, Parent, or Guardian: _____