Primary Care
pediatric dentistry

DR. JENNIFER HOWSON-JONES INC.
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CONSENT TO DENTAL TREATMENT AND MINIMAL OR MODERATE SEDATION

I, the undersigned, consent to treatment on my child _____,

including but not exclusive to dental examination, radiographs, prophylaxis (cleaning) and fluoride treatment, fissure sealants, restorations (fillings and caps), root canal therapies (pulpotomies or pulpectomies), and/or extractions by Dr. Jennifer Howson-Jones. I understand that no guarantee or assurance has been made as to the ultimate result of the procedure(s).

I understand the reason for the procedure(s) to be done under sedation is related to one or more of the following:

Extent of treatment needed, young age, situational anxiety, medical history or other

_____.

Alternatives to the procedure(s) have been fully discussed with me by the dentist named above and include no treatment, local anesthesia alone or in combination with protective stabilization, or general anesthesia.

RISKS:

I give this authorization with the understanding that any procedure may involve certain risks or hazards. I understand that the risks of the procedure(s) include, but are not limited to infection, bleeding, nerve injury, blood clots, allergic reactions, soreness of the mouth, lips, gums and teeth, numbness, fever, nausea and vomiting. I understand that sedation risks include, but are not limited to infection, bleeding, nerve injury, blood clots, allergic reactions, pneumonia, aspiration, soreness of the mouth and nose, numbness, fever, nausea, vomiting, altered heart and breathing rate, brain damage or death. These risks may imply serious, possibly fatal consequences.

ADDITIONAL PROCEDURE:

I further understand that during the course of any treatment, unforeseen circumstances may be revealed that could necessitate the performance of an additional or alternative procedure, which I also consent to being performed on my child.

I, the undersigned, hereby acknowledge receiving a copy of the pre- and post-operative instructions which have been explained to me. I understand the advice given and agree to follow the care instructions closely.

I ACKNOWLEDGE THAT A CANCELLATION CHARGE OF $150 WILL APPLY IF VIOLATION OF THE PREOPERATIVE INSTRUCTIONS LEADS TO CANCELLATION OF THE SCHEDULED TREATMENT AND/OR IF I FAIL TO PROVIDE 48 HOURS NOTICE FOR CANCELLATIONS/CHANGES.

After discharge, I will notify Primary Care if my child experiences any acute pain, heavy bleeding from any surgical sites, respiratory problems, or any other post-operative problems.

I have read this authorization and understand it and give my consent as above. 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 or if I do not understand any of the words contained in the form.

Signature of Parent or Legal Guardian

Relationship to patient

Print Name

Date (MM/DD/YY)

Signature of Witness

Date (MM/DD/YY)

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