

Alamance Family **DENTISTRY**

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Treatment Consent for a Minor

Patient's Name: _____ Date of Birth: _____
Last First M.I.

- State Law requires us to obtain parental consent for dental treatment of a minor. Please read this form carefully and ask about anything that you do not understand.
- In general terms, the dental treatment may or may not include some of the following:
 - Radiographs (x-rays) of teeth and jaws
 - Cleaning and fluoride treatment
 - Sealants
 - Fillings
 - Crowns
 - Extractions
 - Treatment of oral habits or growth abnormalities with orthodontics
 - Utilizing behavior management techniques when necessary (verbal consent from the parent must be given at that time)
- Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. *The most common complications associated with pediatric dental treatment include: nausea following the administration of topical fluoride and children biting and injuring the tongue or lip following the administration of local anesthesia.* Less common complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown, an extracted tooth or gauze packing, injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of bacterial infection of the heart following dental treatment exists; therefore, antibiotics may be prescribed before to minimize the risk.

I hereby state that I have read and understand this consent form. I hereby authorize the doctor and/or dental auxiliaries to perform dental treatment on my child.

Signed: _____
Parent or Guardian

Date: _____

Signed: _____
Treating Dentist

Date: _____

Signed: _____
Witness

Date: _____