



CONSENT FOR DENTAL PROCEDURE

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I give my permission for the dentist to perform the following procedures on me/child/represented person (circle one). In general terms, the dental treatment or procedure(s) will include (check all that apply):

- A. Dental restorative procedure (fillings), including the use of local anesthesia, mouth prop, and/or employing voice control.
B. Photographs, x-rays, and molds of teeth
C. Removal of baby or permanent teeth
D. Inhaled medicines (nitrous oxide) to relax the child
E. Physical restraint, including holding my child /represented person
F. Other

The nature and purpose of the procedures have been explained to me in general terms by Dr. Alternative procedures, if any, have also been explained to me, along with their advantages, disadvantages, and risks. I realize that good results are expected, but the possibility and nature of complications cannot be accurately anticipated; therefore, no guarantees, expressed or implied, can be given for treatment results.

Although their occurrence is not frequent, some risks and complications are known to be associated with dental procedures. The most common of which include children biting and injuring their tongues or lips following the administration of local anesthesia, as well as soreness around the area being treated. In addition, less common complications include the risks of infection and swelling.

I have read and understand this consent form. I have been given an opportunity to ask questions about the treatment. I understand that I have the right to be provided with answers to questions that I might have during the course of my mine, my child, or represented person's treatment. I understand that I am free to withdraw my consent to treatment at any time.

Child's name:

Signature of Parent or Legal Guardian:

Relationship to Child: Date:

Signature of Witness: Date:

Signature of Dentist: Date: