GENERAL CONSENT AND CONDITIONS FOR DENTAL TREATMENT

State Law requires us to obtain consent to your child's dental treatment. Furthermore, we require your agreement to certain conditions prior to performing dental treatment on your child. Please read this form carefully and ask us about anything that you do not understand. We will be pleased to explain it.

1. Consent **for Treatment.** I hereby authorize **Smile Surfers Kids Dentistry doctors**, assisted by qualified dental auxiliaries of their choice to perform upon my child (or legal ward) dental examinations, radiographs (x-rays) and diagnostic photographs, and the following dental treatment including the use of any necessary or advisable local anesthesia:

- Preventative therapies such as prophylaxis, fluoride treatment and sealants
- Treatment of disease of injured teeth with dental restorations (fillings and crowns)
- Extraction of primary and permanent teeth when deemed appropriate
- Replacement of missing teeth with dental prostheses and/or space maintainers
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or developmental or growth abnormalities
- Use of Nitrous Oxide or Oral Conscious Sedation as recommended (see behavior management form for Risks and Benefits).
- Use of Behavior management techniques as deemed necessary by doctor or staff (see behavior management form).

2. Release**.** I also authorize Smile Surfers Kids Dentistry to use photographs, radiographs and other treatment records which do not reveal the identity of my child for the purpose of teaching, research and scientific publication.

3. Disclaimer**.** I understand that **treatment will be explained to me along with the possible alternative methods of treatment including their advantages and disadvantages as evidenced by my signature on the exam form and/or the treatment plan**. I understand that although good results are expected, the possibility and nature of complications cannot be accurately anticipated and there can be no guarantee expressed or implied as to the result of the treatments provided. If I decide to refuse or stop dental care against the advice of doctors Collette and/or Hamilton, and/or the staff at Smile Surfers, that they shall not be held responsible for any poor or unsatisfactory outcomes resulting from this choice.

4. **Disclosure of Risk.** I understand that, even though extremely rare in occurrence, some risks are known to be associated with dental treatment procedures, anesthesia and sedation. These risks are (**Common**): bleeding, swelling, temporary numbness, infection, discoloration, nausea and vomiting; (**Uncommon**): allergic reaction, prolonged or permanent numbness, prolonged pain, fainting; and scarring. I further understand and accept that complications may require hospitalization. **I also understand that all the above risks with the exception of allergic reaction may also occur as a result of dental infection, due to a lack of treatment, if I choose to not pursue treatment for my child.** I understand that refusal to consent to treatment for my child under certain, specific circumstances may constitute neglect.

5. **Remedies.** If, for any reason, a conflict or disagreement should arise at Smile Surfers, I will present such conflict or disagreement to Dr. Collette and/or Dr. Hamilton in order to resolve the problem**.** Your satisfaction is our concern, and we will work hard to exceed your expectations.

6. **Electronics (Cell phones, tablets, gaming systems etc.).** Please be courteous with your use of wireless electronic devices in the office. In particular, **DO NOT PHOTOGRAPH OR TAKE VIDEO OF ANYONE EXCEPT YOUR OWN CHILD**. Ask permission to video or photograph your child so that staff members can assure that privacy laws are followed.

7. **Profanity.** Due to the nature of our practice and being a pediatric provider, the use of profanity or vulgar language is strictly prohibited. If violated, you may be asked to leave and/or dismissed from the practice.

8. **Late.** If you arrive more than 10 minutes late to your scheduled appointment, you may need to be rescheduled.

I hereby state that I have read and understand this form and that my questions concerning consent and conditions for dental treatment have been answered to my satisfaction. I understand that there are information sheets available that detail the risk and benefits of each of the dental treatments which are available upon request. I understand that I have the right to be provided with answers to questions which may arise during my child's treatment. I further understand this consent for treatment will remain in effect until such time that I choose to terminate it.

Patient's Name: 1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

Signature of Parent/Guardian: _____ Relationship to patient: _____

Printed Name of Parent/Guardian: _____ Date: _____