MAPLE RIDGE DENTISTRY for kids

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Dr. Nancy Vertel-Owner
Certified Specialist Restricted to Pediatric Dentistry

CONSENT FOR DENTAL TREATMENT UNDER ORAL SEDATION

I hereby authorize Dr. _____, and whomever he/she may designate as assistants, to perform the following operation and procedures on my child:

White Fillings: _____	**White Crown: _____**	**White Caps: _____**
Silver Fillings: ____	**Silver Caps (SSC):_____**	**Extractions: _____**
Nerve treatments: _____	**Pulp Cap-Direct/indirect:_____**	
Polish: _____	**Fluoride:_____**	**X-Rays:____**
Sealants: _____	**Disking:_____**	**Space Maintainer:_____**

Alternatives to the procedure(s) have been explained to me by the dentist named above and include: no treatment, local anesthesia alone or general anesthesia.

Risks: I give this authorization with the understanding that any procedure may involve certain risks or hazards. I understand that complications are extremely rare but possible. The sedation risks include but are not limited to nerve injury, allergic reactions, aspiration, vomiting, fever, nausea, vomiting and in extreme rare cases respiratory depression leading to brain damage or death.

I, the undersigned, herby consent treatment on my child_____ to the procedure(s) noted 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 _____ Date _____

*Patient * Parent *Legally Authorized Representative

Witness _____Date _____

I acknowledge receiving a copy of the pre- and post-operative instructions which have been explained to me. I understand all the advice given to me by my dentist. After my discharge, I will notify my dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems.

Signature _____ Date _____

*Patient * Parent *Legally Authorized Representative