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Certified Specialist in Pediatric Dentistry

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CONSENT FOR DENTAL TREATMENT UNDER GENERAL ANESTHESIA

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:**_____
Pulpotomy:_____	**Pulpectomy:**_____	**Pulp Cap-Direct/indirect:**_____
Polish:_____	**Fluoride:**_____	**X-Rays:**____
Sealants:_____	**Disking:**_____	**Space Maintainer:**_____

ANESTHETIST _____

I, the undersigned, hereby consent treatment on my child_____ to the procedure(s) noted above. I acknowledge that the procedure(s), its implications and possible complications have been explained to me, along with the alternatives including not having any treatment. I understand that during the course of any treatment, unforeseen circumstances may arise that make it advisable for an additional or alternate procedure to be performed, which I also consent to being performed.

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*