Laxer, Long&Savage
Specialists In Pediatric Dentistry & Orthodontics

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PEDIATRIC DENTISTRY CONSENT for DENTAL PROCEDURES and ACKNOWLEDGEMENT of RECEIPT of INFORMATION

Please read this form carefully. If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it.

I hereby authorize and direct Drs. Laxer, Long and Savage assisted by dental auxiliaries of their choice to perform the following dental treatment.

In general terms the dental procedure(s) or operation will include:

_____ A. Cleaning of the teeth and application of topical fluoride
_____ B. Dental x-rays
_____ C. Application of "sealant" to the grooves of teeth
_____ D. Treatment of diseased or injured teeth with dental restorations
_____ E. Replacement of missing teeth with dental prosthesis
_____ F. Removal of one or more teeth
_____ G. Use of physical restraint or restraining devices to safely accomplish necessary dental procedures.
_____ H. Use of sedative drugs to control apprehension and/or disruptive behavior
_____ I. Use of General Anesthesia to accomplish the necessary treatment
_____ J. Use of Analgesia, inhalation of nitrous oxide "happy air"
_____ K. Orthodontic treatment/tooth movement

This treatment has been explained to me. Alternative methods of treatment, if any, have also been explained to me. I am advised that, though good results are expected, the possibility and nature of complications cannot be completely anticipated. Therefore, there can be no guarantee either expressed or implied as to the result of the treatment or as to the cure. I further authorize the doctors to perform other dental services that, in their judgment, are advisable for my child or legal ward.

I hereby state that I have read and understand this consent, and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment

I further understand that this consent will remain in effect until such time that I chose to terminate it.

Date: _____ Patient's Name: _____
Signature of Parent or Guardian: _____
Signature of Witness: _____

CONSENT