half moon
dentistry for children

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PATIENT'S CONSENT FOR TREATMENT UNDER GENERAL ANESTHESIA

PROCEDURE(S) Radiographs, preventive and restorative treatment of teeth and/or extractions of non-restorable teeth under general anesthesia

OPERATING DENTIST

_____

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*