half moon
dentistry for children

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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.

I, understand that a deposit of _____________ is required to obtain a surgical dental appointment. This deposit will become **non-refundable** if the booked appointment is **missed** or you have **not complied** with the pre instructions for the procedure.

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*

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