Pediatric Dentistry
for infatns, children and teenagers

3500 Barranca Pkwy, Suite 260
Irvine, CA 92606

PEDIATRIC DENTISTRY CONSENT for DENTAL PROCEDURE and ACKNOWLEDGMENT of RECEIPT of INFORMATION

State Law requires us to obtain your consent to your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.

I hereby authorize Teddy Bear Dental, Dr.Ted I Kim , assisted by dental auxiliaries of his choice to perform upon my child (or legal ward) the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) and diagnostic aids.

Please Initial any procedure you DO NOT desire to be done on your child AT ANY TIME:

____ A. Application of plastic "sealants" to the grooves of teeth.
____ B. Treatment of diseased or injured teeth with dental restorations (fillings).
____ C. Replacement of missing teeth with dental prosthesis.
____ D. Removal (extraction) of one or more teeth.
____ E. Treatment of diseased or injured oral tissues (hard and/or soft).
____ F. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
____ G. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
____ H. Use of sedative drugs to control apprehension and/or disruptive behavior.
____ I. Other: ____
____

This treatment has been explained to me, alternate methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages of each and possible results of no treatment. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee expressed or implied either as to the result of the treatment or as to cure. I further authorize the doctor to perform other dental service(s) that in his judgment are advisable for my child or legal ward, with the exception of: ____
____

3. Although their occurrence is extremely remote, some risks are known to be associated with dental or oral surgery procedures, including anesthesia or sedation. State Law requires us to mention the risks of numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, quadriplegia, paraplegia, the loss or loss of function of an organ or limb, or disfiguring scars associated with such procedure or procedures. I further understand and accept that complications may require hospitalization and may even result in death.

4. **I UNDERSTAND THAT ALL OF THE ABOVE WITH THE EXCEPTION OF ALLERGIC REACTION, MAY ALSO OCCUR DUE TO DENTAL INFECTION IF I CHOOSE NO TREATMENT BE GIVEN TO THE PATIENT.**

5. I also authorize Teddy Bear Dental, Dr. Ted I Kim to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

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 which 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 CHOOSE TO TERMINATE IT.

Date: ______________________ Time ______________ am/pm File Number ______________________

Patient's Name ____

Signature of Parent or Guardian ____

Relationship to Patient ______________________________ Witness ______________________

I certify that I explained the above procedures to the parent or legal guardian before requesting their signature.

____
(Signature of Dentist/Assistant)