SUNRISE
Pediatric Dentistry

CONSENT FOR DENTAL TREATMENT UNDER ANESTHESIA

I authorize Dr. Elizabeth Crespi to perform the following operation or procedure: **full mouth dental rehabilitation** including, but not limited to:

X-rays	**Sealants**	**Silver fillings**	**White fillings**
◯ YES	◯ YES	◯ YES	◯ YES
◯ NO	◯ NO	◯ NO	◯ NO

Silver crowns	**White crowns**	**Root Canals (Pulpotomy)**
◯ YES	◯ YES	◯ YES
◯ NO	◯ NO	◯ NO

Extractions	**Space Maintainers**	**Cleaning**	**Fluoride**
◯ YES	◯ YES	◯ YES	◯ YES
◯ NO	◯ NO	◯ NO	◯ NO

I understand the reason for the procedure or operation is: **to eliminate cavities and/ or infections caused by dental disease**. Alternatives to this operation or procedure have been fully discussed with me by the dentist named above.

Initial ☐

Risks: I give this authorization with the understanding that any operation or procedure may involve certain risks or hazards. **I understand that such risks include, but are not limited to: infection, bleeding, nerve injury, blood clots, allergic reactions and pneumonia.** These risks may imply serious, possibly fatal consequences. **The major significant risks of this particular procedure include: pain, bleeding, infection and fever.**

Initial ☐

Anesthesia: I understand that administration of anesthesia also involves risks, most importantly a reaction to medications causing death. I understand that such reactions are rare, but the possibility exists. I consent to the use of such anesthetics as may be considered necessary by the person responsible for administration of these medications or anesthetics. I understand these and other risks related to the giving of anesthetics will be discussed with me by the anesthesiologist.

Initial ☐

Additional Procedures: If my physician/dentist discovers a different unsuspected condition at the time of surgery, I authorize him/her to perform such operation or procedure that he/she deems necessary.

Initial ☐

I understand that the success of the treatment being rendered relies in part by my child's oral hygiene practices, diet and other factors, after the procedure is complete. Dr. Crespi recommends routine dental exams/follow up visits to monitor the teeth being treated today.

Initial ☐

Parent's Name:

Relationship to child

Child's Name:

Date:

Time:

Signature:

Physician/Dentist Declaration: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge I feel the patient has been adequately informed and has consented to the procedure detailed above.

Elizabeth Crespi, D.M.D.

Date:

Time: