



## PARENTAL CONSENT FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please read the following information describing your child's/dependent's dental care, which may or may not be applicable to the procedures and treatment prescribed at this visit. Please ask your Dental Assistant, Hygienist, and Dentist to address any questions or concerns you may have regarding the prescribed treatment:

I authorize the use of:

- Intraoral dental x-rays
- The use of anesthetics considered necessary and/or advisable by the clinical facility to diagnose and/or treat the patient's dental problem(s).

The common and most frequently occurring risks or complications occurring from the planned treatment and procedures have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during and following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

I understand that during the course of the patient's dental treatment unexpected observations, may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of these treatment procedures. I am aware that the practice of dentistry is not an exact science, and hereby acknowledge no guarantees have been made to me concerning the results of the dental treatment the patient will receive.

I understand at Riccobene Associates, dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. We will provide a clinical environment that intended to help children to cooperate during treatment. To accomplish this, the patient's behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

I understand should the patient become uncooperative during dental procedures with movement of the head, arms and or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head, and/or control leg movements. If we still cannot provide safe treatment we will reschedule the patient.

I have had explained to me, and I have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

I understand that I may revoke this consent at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.



I confirm that I have read and understand this form, and thus consent to Riccobene Associates to conduct the procedures and or treatment as prescribed by the treatment plan.

\_\_\_\_\_  
Parent/Guardian Signature for Consent to Treat

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient

**CONSENT CERTIFICATION**

I certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, the alternatives to the treatment and procedures prescribed regarding this treatment plan. I have actively inquired to answer any questions and have fully addressed such questions and concerns. I believe the patient/relative/guardian understands what I have explained, and has willfully consented to the prescribed treatment and procedures.

\_\_\_\_\_  
Treating Dentist Signature

\_\_\_\_\_  
Date

**WITNESS CERTIFICATION**

I hereby certify that the patient/relative/guardian either, has acknowledged in my presence that he/she has received an explanation of, and alternatives to, the proposed dental treatment/procedures, usual and most frequent risks and hazards of, and the alternative to the proposed treatment/procedures, has had all of his/her questions answered, has given his/her consent, and has signed this form where indicated: or after the informed consent discussion and signatures above, has answered "yes" to all of the following questions:

1. Did the doctor explain the treatment and procedures to you?
2. Have all of your questions about the treatment and procedures been answered?
3. Is this your signature on the consent form?
4. Have you given your consent to the proposed treatment and procedures?

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name