STOVALL
DENTAL

Treatment Consent for a Minor

Patient's Name: _____

Date of Birth: _____

Please read this form carefully and ask about anything that you do not understand.

In general terms, the dental treatment may or may not include some of the following:

- Radiographs (x-rays) of teeth and jaws
- Cleaning and fluoride treatment
- Sealants
- Fillings
- Crowns
- Extractions
- Any other dental concerns

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include: nausea following the administration of topical fluoride and children biting and injuring the tongue or lip following the administration of local anesthesia. Less common complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown, an extracted tooth or gauze packing, injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of bacterial infection of the heart following dental treatment exists; therefore, antibiotics may be prescribed before to minimize the risk.

I hereby state that I have read and understand this consent form. I hereby authorize the doctor and/or dental auxiliaries to perform dental treatment deemed advisable on my child weather or not I am present when the treatment is rendered. I understand payment for the treatment is my responsibility weather I am present or not.

Signed: _____ Date: _____

Parent or Guardian

200 North Leslie Street, Goldsboro, NC 27530 919-581-9300
1504 Wayne Memorial Drive, Goldsboro, NC 27534 919-735-3431