



## CONSENT TO PERFORM DENTISTRY

I authorize and direct Dr. Kaaren Vargas, and dental auxiliaries of her choice, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

- A. Cleaning of the teeth and the application of topical fluoride.
- B. Application of sealants to the grooves of the teeth.
- C. Treatment of diseased or injured teeth with dental restoration (fillings), crowns, and nerve treatment.
- D. Replacement of missing teeth with dental prosthesis.
- E. Removal (extraction) of one or more teeth
- F. Treatment of diseased or injured oral tissues (hard and/or soft).
- G. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
- H. Use of sedative drugs or general anesthesia to control apprehension and/or disruptive behavior.
- I. Postponing or delaying treatment at this time.
- J. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities including a deimpactor or spacemaintainers.

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages and risks of each. I am advised that through good results are expected, the possibility and nature of complication cannot be accurately anticipated and that, therefore, there can be no guarantee either expressed or implied, as to the result of the treatment or as to the cure.

I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well being in the professional judgment of Dr. Kaaren Vargas.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure. Including:

1. Drug or chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
2. Long-term numbness (paresthesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.

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3. Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. Sensitivity of teeth or gums, infection, or bleeding.
5. Swallowing or inhaling small objects.

While we follow procedural guidelines which most often lead to a clinical success, just like any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor. I understand that nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. In addition, the use of local anesthesia can result in long-term numbness that usually resolves itself. Needle breakage could also occur which would require surgical removal.

I authorize the use of voice control should my child become disruptive. The attention of a disruptive child is gained by changing the tone or the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.

I also authorize the doctors to photographs, radiographs, other diagnostic material and treatment records for the purposes of teaching, research and scientific publications.

I understand that the alternative to these methods of treatment is to not perform the recommended dental treatment.

I hereby state that I have read and understand this. Further, all questions about the procedures have been answered in a satisfactory manner and I understand that I have the right to be provided 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.

**Signature** (Parent/Legal Guardian) \_\_\_\_\_ **Date:** \_\_\_\_\_

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