pediatric dental center
professional corporation

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CONSENT FOR DENTAL TREATMENT

Patient:_____

1) I hereby authorize the doctors of Pediatric Dental Center, and their dental auxiliaries to perform a dental examination, prophylaxis, x-rays and fluoride treatment as deemed necessary.

2) I acknowledge that I have been given a copy of this signed consent form prior to the dental examination, prophylaxis, x-rays and/or fluoride treatment.

3) I will be advised of any restorative dental procedures my child may require. Any procedure needed will be fully explained to me prior to treatment. Although good results are generally anticipated, no guarantees either written, oral or implied have been made by anyone at Pediatric Dental Center regarding the outcome of the proposed restorative procedures. I hereby authorize the doctors of Pediatric Dental Center to perform the recommended procedures.

4) In the event that my child requires restorative dental procedure, I give my consent to the use of local anesthesia and nitrous oxide analgesia in conjunction with the recommended dental treatment.

5) I understand that occasionally there are complications with the use of local anesthetics, including, but not limited to:
   - Numbness of the face, cheek, lips and tongue
   - Soreness at the injection site
   - Swelling, Discoloration or Bruising
   - Post treatment lip and tongue biting
   - Allergic response to local anesthesia, including severe allergic response requiring hospitalization

6) I have read and fully understand the above consent to restorative procedures. I acknowledge receiving a copy of this signed consent to restorative procedures prior to the performance of those procedures.

Signature of Parent/Guardian: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Pediatric Dental Center all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date Signature