Child's Consent For Procedure

I (we) hereby request and consent to the performance of comprehensive dental treatment including radiographs (x-rays) and photographs (pictures) by Dr. Payton Southall, associate dentists, and their staff. I also request and consent to the administration of anesthetics (numbness) and disposal of any body tissue as deemed advisable by the dentist performing the operation or procedure.

Operations and procedures include examination, radiographs, periodontal treatment (cleaning and scaling), fluoride application, sealants, restorations (fillings), crowns, endodontic treatment (root canal treatment), extractions, Silver Diamine Fluoride (SDF), and space maintainers.

I acknowledge that I have had an opportunity to discuss with the dentist about the operation or procedure, its purpose and nature, reasonable alternatives, possible consequences of remaining untreated, and risks and possible complications. I understand that the practice of dentistry is not an exact science, that it may involve the making of dental judgments based upon the facts known to the dentist at the time, that it is not reasonable to expect the dentist to be able to anticipate nor explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results have been made to nor relied upon by me, and I wish to rely on the dentist to exercise judgment during the course of the procedure or operation which he or she feels at the time, based upon the facts then known, are in my best interest.

_____ _____

WITNESS TO SIGNATURE PATIENT'S NAME

_____ _____

DATE PARENT'S SIGNATURE (LEGAL GUARDIAN)