Ottesen
FAMILY DENTISTRY

Consent for Dental Treatment
Without Parent or Guardian Present

I, the undersigned, understand and authorize the doctor to take radiographs (x-rays), study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated or that may be deemed necessary by the doctor.

I understand that the use of local anesthetics embody a certain risk. Complications and side effects are rare, but may include, among others not listed: swelling, bruising or soreness at the injection site, numbness outside of the mouth, temporary rapid heartbeat, damages to the nerves resulting in temporary or possibly permanent numbness or tingling of lips, chin, tongue or other areas, severe allergic and possible life threatening reactions necessitating emergency care. I understand that if my child has high blood pressure, uncontrolled thyroid problems, angina or has recently had a heart attack I will inform my dentist verbally without fail as these conditions have caused complications for persons receiving local anesthesia. I understand that it is my responsibility to report any changes in my child's medical history. I assume the right and responsibility to ask for any alternative treatments, as well as the financial responsibility of all treatment provided.

I consent for my child to have the following services provided at his or her preventative care appointment.

	Yes	No
Diagnostic x-rays / radiographs	☐	☐
Topical application of fluoride	☐	☐
Sealants	☐	☐

I consent for dental treatment to be performed on my child when not in the presence of myself or other guardian. My signature acknowledges that I have asked and have had answered any and all questions associated with any of the above issues.

_____
Name of Patient Date of Birth

_____ ( )
Local Emergency Contact Relationship Phone Number

X_____
Signature of Parent or Guardian Date