



## INFORMED CONSENT FOR PEDIATRIC DENTAL X-RAYS AND EVALUATION

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered to your child.

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

### **EXAM**

Every child is a unique individual thus not every child will require the same treatment to obtain a comprehensive oral examination. Based upon your child's age, teeth present, and tooth position, **Dr. Jeremy Wittich** will determine if radiographs (x-rays) are necessary. In general, the examination appointment also includes cleaning of the teeth and application of topical fluoride.

### **TREATMENT**

If your child should need any dental treatment after the dental examination has been completed, **Dr. Jeremy Wittich** will review the planned treatment with you. Please read the following information regarding dental treatment at our office.

- It is our policy that all treatment options are explained to the parent(s), including treatment alternatives, advantages, and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.
- Risks that are occasionally associated with dental treatment procedures include: numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infection. On rare occasions complications may arise that require hospitalization.
- I agree to remain within the dental office facility where my child is being treated.

With my signature I authorize Children's Dentistry of Kyle to expose x-rays for diagnostic purposes and perform a dental exam upon my child and I acknowledge that I have reviewed the possible risks and complication associated with dental examination and x-rays.

\_\_\_\_\_  
Parent/ Legal Guardian Printed Name

\_\_\_\_\_  
Parent/ Legal Guardian Signature

\_\_\_\_\_  
Date

*For office use only:*

TREATING DENTIST: **JEREMY WITTICH DDS**

\_\_\_\_\_  
Witness/Staff Signature