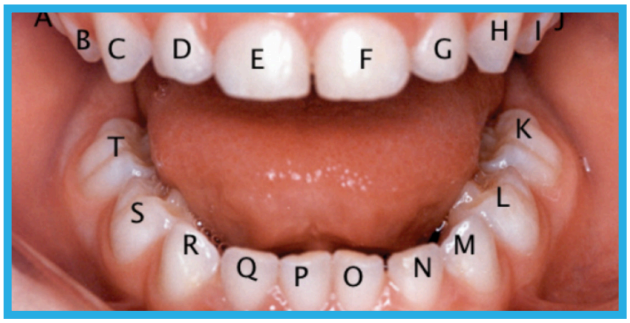
Extraction Consent

I UNDERSTAND THAT BY SIGNING BELOW I AM REQUESTING AND AUTHORIZING THE PROCEDURE(S) TO BE PERFORMED ON MY CHILD AND I HAVE READ AND UNDERSTAND THE POSSIBLE RISKS AND COMPLICATIONS OF THE PROCEDURE(S).

Removal of Teeth

Risks, benefits and alternatives to treatment have been discussed by the Dentist prior to the procedure. Alternatives, if appropriate, to removal of my child's teeth have been explained to me in detail (Pulpotomy or "baby root canal therapy" and Crowns) and I have elected for extraction.

I authorize Dr. _____ to remove teeth #(s): _____



and any others deemed necessary by the Dentist in the course of treatment. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the following risks associated with having teeth removed: pain, spread of infection, dry socket, swelling, damage to nearby teeth, fractured jaw, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time. I understand my child may need further treatment, the cost of which is my responsibility.

Local Anesthesia

In connection with my child's dental work, local anesthetic may be used. Local anesthesia is commonly used during dental treatment and complications are rare but do at times occur. Risks that can be associated with local anesthesia include dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or additional medical management or hospitalization. In addition, my child may experience restricted mouth opening during recovery, sometimes related to muscle soreness at the site of the injection requiring physical therapy. Local anesthesia may cause prolonged numbness that in some patients may result in injury from biting or chewing an area (lip, cheek or tongue) that has received the local anesthesia. Local anesthesia can cause injury to nerves that can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gum, or tongue which may persist for several weeks, months, or, in rare cases, may be permanent. Local anesthesia is administered with a very fine needle. In rare instances these needles may break off or separate from the hub and become lodged in soft tissue.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/or all changes and additions as necessary.

Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage. The above procedure has been fully explained to me. I have provided the Dentist with a complete review of my child's medical history.

I CONSENT TO TREATMENT OF MY CHILD AS EXPLAINED ABOVE. ALL OF MY QUESTIONS HAVE BEEN ANSWERED REGARDING THE ABOVE TREATMENT.

Parent's Name

Child's Name

Parent's Signature

Date

Witness Signature

Date