V.8.4.2020

ST. LOUIS pediatric dentistry

Start them Smiling®

St. Louis Pediatric Dentistry General Consent for Treatment

Patient Name:_____ Date of Birth:_____

State Law requires us to obtain your consent for any contemplated dental treatment or oral surgery. However, prior to any treatment, it is necessary to perform a thorough clinical evaluation including any diagnostic aids necessary. Please read this and ask about anything you don't understand. We will be pleased to explain it.

I hereby authorize and direct Dr. Evan Reed, Dr. Lindsey Reed, Dr. Amy LeCave, Dr. Jaime Orrick, Dr. Danielle West, and/or Dr. Allison Buford, assisted by other dental auxiliaries of his/her choice to perform upon my child (or legal ward) a complete dental examination including the advisable radiographs (x-rays) and any other diagnostic aid deemed necessary by Evan Reed, Dr. Lindsey Reed, Dr. Amy LeCave, Dr. Jaime Orrick, Dr. Danielle West, and/or Dr. Allison Buford, in order to properly diagnose the dental condition of my child. I also understand that if any dental treatment is necessary, I will be required to sign consent for treatment after having been explained the proposed treatment.

GENERAL CONSENT FOR TREATMENT

State Law requires us to obtain your consent for contemplated dental treatment. This form serves as a general consent for dental treatment. Please read this form carefully and ask about anything you do not understand. We will be glad to explain it.

1. After consultation with Evan Reed, Dr. Lindsey Reed, Dr. Amy LeCave, Dr. Jaime Orrick, Dr. Danielle West, and/or Dr. Allison Buford, and explanation about any proposed procedure, I hereby authorize and direct Dr. Evan Reed, Dr. Lindsey Reed, Dr. Amy LeCave, Dr. Jaime Orrick, Dr. Danielle West, and/or Dr. Allison Buford, assisted by other dental auxiliaries of his/her choice to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s) including the necessary or advisable local anesthesia radiographs (x-rays) or diagnostic aids.

2. In general terms the dental procedures may include one or a combination of the following:

- **Cleaning of the teeth and the application of topical fluoride.**
- **Dental radiographs**
- **Application of plastic "sealants" to the grooves of the teeth**
- **Intraoral photographs of the teeth**
- **Treatment of disease or injured teeth with dental restorations.**
- **Replacement of missing teeth with dental prosthesis.**
- **Removal (extractions) of one or more teeth.**
- **Treatment of disease or injured oral tissues (hard and/or soft).**
- **Treatment of malposed (crooked) teeth and/or developmental abnormalities.**

Alternative methods of treatment, if any, will also be explained to me, as will the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.

I hereby state that I have read and understand this consent, and that all questions about this consent or any planned procedure have or will be answered in a satisfactory manner prior to any treatment. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

_____ _____

Signature Relationship

_____ _____

Witness Date/Time

O'Fallon P: (636) 244-2620 | Des Peres P: (314) 394-1914 | Chesterfield P: (636) 778-2333 | Ladue P: (314) 899-0881

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