General Consent Form - Child

I, _____ authorize Dr. Hendrick and his Assistant/Hygienist to perform my child's treatment plan. I have had the opportunity to discuss with the Dentist my child's medical history indicating any serious problems, injuries, or allergies. I have had explained to me and have had sufficient opportunity to discuss my child's dental conditions, planned procedures and treatments. I have had explained to me the expected benefits from this treatment in comparison with alternative approaches or no treatment.

I authorize dental x-rays to be taken on my child. I understand x-rays are advisable and necessary to diagnose and treat my child's dental conditions. I am also aware, continually refusing dental x-rays can result in dismissal from the practice.

I understand that antibiotics, analgesics, and other medications can cause drowsiness, lack of coordination, nausea, redness, swelling of tissues, pain, and itching, vomiting, and serve allergic reactions (anaphylactic shock). Local anesthesia can cause a tingling sensation in the lip, chin, tongue, cheek, teeth or gums that could be temporary or permanent. I will monitor my child after their dental appointment to insure he/she is not biting his/her tongue, cheek, or lips because it could result in swelling, pain or bruising. If any of these symptoms occur, I will contact the Dentist's office immediately. It is also not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may administer or prescribe. Alcohol may also increase these effects. Antibiotics are known to decrease the effectiveness of oral contraceptives.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. The most common being, root canal therapy following routine restorative procedures. I give my permission for the Dentist to make these changes as he deems necessary.

I understand that some dental procedures may cause changes in occlusion (biting), jaw or muscle cramps, spasms, referred pain to the ear and/or neck. I understand that there is always a possibility of delayed healing and/or treatment failure.

The usual and most frequent risks or complications include, but are not limited to: pain, discomfort during or following procedure, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, permanent or temporary temporomandibular (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

I understand that treatment for my child may include efforts to guide behavior . I am aware the Dentist nor any of the other dental staff will ever restrain my child to the dental chair. Should my child become uncooperative during a dental procedure, the assistant may hold my child's hands, stabilize his/her head and/or control leg movements. These necessary measures are taken to ensure my child's safety. If major behavioral issues arise, my child may be referred to a specialist for treatment.

I understand that delay in treatment may result in changes to his/her treatment plan may result in added expense.

All of my questions have been answered to my satisfaction and I consent to general treatment.

_____ Date: _____

Signature of Parent or Guardian

_____ Date: _____

Witness