Consent for Treatment of a Minor

In providing dental care, we will treat your child as we would our own. Dentistry is an important health service for your child, and it is our goal to provide him/her with a satisfying experience in our office. Please read this form carefully. Should you have any questions, or staff will be happy to help you.

1. I hereby authorize and direct Dr. Loiben, associates and the staff of Ted Loiben DDS Pediatric Dentist Ltd. to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand certain parts of the treatment may be performed by certified paraprofessionals (dental hygienists and assistants) other than the dentist.
3. I understand x-rays, photographs, models of the mouth and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request, some for a fee.
4. In general terms, the dental procedure(s) can include but not be limited to:
    a. Comprehensive oral examination, radiographs, cleaning of the teeth and the application of topical fluoride.
    b. Application of sealants to the grooves of the teeth.
    c. Treatment of diseased or injured teeth with dental restorations, stainless steel or composite crowns, and/or root canal treatment.
    d. Oral surgery, extraction of one or more teeth, excision of hyperplastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth.
    e. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
    f. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
    g. Treatment of habits, malposed crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities.
5. I authorize the use of accepted behavior management techniques including nitrous oxide analgesia in order to complete treatment for my child.
6. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.
7. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.
8. I have answered all the questions about my or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies. I will not hold Dr. Loiben or any of his staff responsible for any errors or omissions I may have made. I also understand if I or my dependent ever have any changes in health status or any changes in medications, I will inform the doctor at the next appointment.
9. I authorize Ted Loiben DDS Pediatric Dentist LTD to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care provider for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read and understand this consent & the meaning of its contents. All questions have been answered in a satisfactory manner & I believe I have sufficient information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

______________________________ ____________________

Patient's Name Date

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Parent or Guardian Relationship to Patient