Wachusett Pediatric Dentistry
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DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the bottom of the form

√ _____ 1. WORK TO BE DONE

I understand that my child will be having the following work done:

Fillings _______ SS Crowns _______ Extractions _______ Other _______

Initials ________

√ _____ 2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Initials ________

√ _____ 3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add prccedures because of conditions found while working on the teeth that were not discovered during examination, the most common being Therapeutic Pulpotomy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Initials ________

______________________________ ______________________

Patient Signature Date

______________________________ ______________________

Dentist Signature Date

______________________________ ______________________

Witness Signature Date