

**Ellen Mark DDS Pediatric Dentistry**  
 520 Cottonwood Street #3 Woodland, CA 95695  
 (530) 662-7558

**Pediatric Dental Treatment Consent Form**

As health professionals, it is necessary that we obtain your consent for treatment on your child:

(name) \_\_\_\_\_ Please read this form carefully and ask any questions.

1. I \_\_\_\_\_ authorize Dr. Ellen Mark, associate doctors and staff to treat my child for the following general dental treatments:

Initial for consent below:

	A. Dental Cleaning, fluoride application and radiographs as necessary.
	B. Application of sealants to dental fissures.
	C. Extraction or one or more teeth.
	D. Use of Analgesia = Nitrous Oxide.
	E. Use of sedative drugs for the control of nervous or negative behavior.
	F. Use of physical restraints to properly and securely perform necessary dental procedures.
	G. Use of "voice control" in order to gain attention of children with negative behavior
	H. Silver fillings / White fillings
	I. Nerve Treatments.
	J. Stainless steel crowns /White crowns / Open face crowns
	K. Appliances.
	L. Local Anesthesia.
	M. Other:

My child's treatment, risks, alternative methods of treatment, including no treatment, as well as advantages and disadvantages of each have been explained to me. All my questions have been answered. I have been advised that although the best results are expected, there is no way within reason of anticipating complications. Therefore it is not possible to guarantee the results or a cure. Although the occurrence is extremely remote, it is known that some risks are associated with dental treatment.

We are required to mention the following; numbness, infection, damage to central nervous system, reduction or loss of function of internal organs or limbs, as well as disfiguring scars. I understand that certain complications may be fatal or require future medical intervention.

\_\_\_\_\_  
 Parent or Guardian Signature

\_\_\_\_\_  
 Date