

Small World Pediatric Dentistry, P.C.
Andrew Guthrie, D.D.S., M.S.D.

CONSENT FOR DENTAL PROCEDURES

Patient's Name: _____

1. I hereby authorize Dr. Guthrie, his associates and staff to perform upon me (or the named patient) one or more of the following procedures described in lay terms: fillings (restorations), caps (crowns), teeth pulling (extractions), nerve treatments (pulpotomies), sealers (sealants), cleaning (prophylaxis), fluoride treatment, spacers (space maintainers), Novocain injection (local anesthetic injection), laughing gas (nitrous oxide analgesia), techniques to help with the behavior of child patients, and/or other procedures. Notes: _____
2. Dr. Guthrie and/or his associates and staff have fully explained the purpose of the procedure(s) as well as the expected benefits and complications (from known and unexpected causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment at all. The attendant risks of no treatment have been discussed. I have been given opportunity to ask questions, which have been answered fully to my satisfaction.
3. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment of Dr. Guthrie.
4. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s).
5. I confirm I have read and fully understand the above and that all blank spaces were completed prior to my signing this document.

Patient's (or Legal Guardian's) Signature

Relationship

Date

Dentist/Dental Staff Certification: I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and the attendant risks) the proposed procedures. I have offered to answer any questions and have fully answered all such questions. I believe the patient/relative/guardian fully understands the nature and risks of the proposed treatment and has given voluntary consent to proceed.

Dentist's/Dental Staff Signature

Date

Please Print and return by email to staff@smallworldokc.com or fax to (405)-946-0687