
INFORMED CONSENT FOR DENTAL TREATMENT

At Augusta Children's Dental Center, all patients are screened regularly for dental cavities, growth and development, treatment needs, and any other oral conditions and risks.

By signing this consent as the parent/legal guardian of: _____,

DOB: _____, I understand the nature of care and agree to allow Dr. Akindeko Obebe to perform the recommended examinations, and/or procedures necessary for proper diagnosis and treatment of my child per the guidelines set forth by the ADA and ABPD. (American Dental Association, American Board of Pediatric Dentistry)

I will comply with office policies, take the opportunity to ask questions concerning recommended treatment and procedures, and discuss any/all treatment completions with the doctor and/or other qualified members of staff.

I agree to allow the following procedures for my child:

- ☒ Comprehensive exam (new patients)
- ☒ Periodic exam (established patients)
- ☒ Prophylaxis (cleaning/polishing of teeth)
- ☒ Fluoride varnish treatment (recommended twice per year by ADA)
- ☒ Dental x-rays (mandatory for proper diagnosis)
- ☒ Dental sealants placed on permanent teeth (when recommended)
- ☒ Silver fillings (Amalgam – no mercury, back teeth only)
- ☒ Composite fillings (tooth colored – depending on level of cooperation)
- ☒ Crowns (stainless steel on back teeth, composite over steel on front teeth)
- ☒ Nerve treatment (baby root canal - for baby teeth that **can** be saved)
- ☒ Tooth removal (for teeth with infection or badly broken down – **cannot** be saved)
- ☒ Space maintainers (holds space where baby tooth is lost early, to prevent permanent tooth eruption issues)
- ☒ Nitrous Oxide (Behavior management – minor analgesic, when inhaled helps reduce anxiety and fear)

I, as the parent/legal guardian, understand that by NOT adhering to office policies or following through with recommendations by Dr. Obebe my child may be at risk for the following:

- ☒ Future cavities ☒ Loss of Fillings ☒ Failure of nerve treatment ☒ Loss of teeth
- ☒ Bleeding ☒ Sore teeth/gums ☒ Root resorption ☒ Infection ☒ Pain

Parent Signature: _____

Printed name: _____ Date: _____

❖ This informed consent is valid from the signature date and will remain constant until the patient is withdrawn from the practice or graduates to the "Adult dentist" for continuation of care.