HENRY DELCLOS, D.D.S.
2225 William Trace Blvd. Suite 106
Sugar Land, TX 77478

CONSENT TO PERFORM DENTISTRY

1. I here by authorize and direct Dr. Henry Delclos and/or dental auxiliaries of his choice, to perform (as deemed necessary) upon my child (or legal ward) the following dental treatment or oral surgery procedure (s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

   The Provider will consult with the responsible party and obtain verbal consent prior to performing any of the following:

   A. Cleaning of the teeth and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings).
   D. Replacement of missing teeth with dental prosthesis.
   E. Treatment of diseased or injured oral tissues (hard and/or soft).
   F. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
   G. Use of sedative drugs to control apprehension and/or disruptive behavior.
   H. Postponing or delaying treatment at this time.
   I. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
   J. The removal (extraction) of one or more erupted teeth.
   K. The use of IV sedation.
   L. Other _____

2. I understand that there are risks involved in dental treatment and hereby acknowledge that these risks will be explained to me, that I have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous/oxygen analgesia depending on the judgment of the doctor. I understand that nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose-piece leaves an indentation or ring around the nose which disappears shortly after the procedure.

As needed, alternate methods of treatment, if any will be explained to me, as will the advantages, disadvantages, and risks of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee either expressed or implied, as to the treatment or as to the cure.

I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well being in the professional judgment of Dr. Henry Delclos.

4. I understand that there are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reaction, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medication in respiratory and

cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

5. I am aware that it is sometimes extremely difficult to perform dental treatment on a child because of lack of cooperation. This is fairly common in very young and immature children, in those children with physical and/or mental handicaps, which diminish their ability to cooperate fully with the procedures, and in children who are fearful or anxious. I hereby authorize the use of a papoose board, the use of a mouth prop, and the assistance of a dental auxiliary in holding my child, <u>if in the doctor's opinion</u> my child needs to be restrained during treatment for his/her safety.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. The alternative to these methods of treatment are:

    a. Do not perform the recommended dental treatment.
    b. Have the treatment performed under a general anesthetic at a hospital. The child would be completely asleep throughout the procedure. An M.D. Anesthesiologist, under the safest possible conditions, would administer the anesthetic.

8. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents will follow post-operative manner and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist must be maintained.

I hereby state that I have read and understand this consent, and that all questions about the procedures have been answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during the course of my child's treatment. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantee has been made to me as a result of the procedures authorized above.

Date: _____ Time: _____ AM/PM.

Patient's Name: _____

Name of Parent or Guardian: _____

X _____
Signature of Parent or Guardian

Witness: _____

Dentist Signature _____