Dr. Wendy Tang Inc. BSc, DMD, MSc, FRCD(C), FCDS(BC)
Certified Specialist in Pediatric Dentistry

CONSENT TO DENTAL TREATMENT AND MINIMAL OR MODERATE SEDATION

I, the undersigned, consent to treatment and sedation on my child ________________________________, including but not exclusive to dental examination, radiographs, prophylaxis (cleaning) and fluoride treatment, restorations (fillings and caps), root canal therapies (pulpotomies or pulpectomies), and/or extractions by Dr. Wendy Tang or her associate(s). I understand that no guarantee or assurance has been made as to the ultimate result of the procedure(s).

I understand the reason for the procedure(s) to be done under sedation is related to one or more of the following: **Extent of treatment needed, young age, situational anxiety, medical history or other** _____________. Alternatives to the procedure(s) have been fully discussed with me by the dentist(s) named above and include no treatment, local anesthesia alone or in combination with protective stabilization, or general anesthesia in a private or public surgical facility.

Additional procedure: I further understand that during the course of any treatment, unforeseen circumstances may be revealed that could necessitate the performance of an additional or alternative procedure, which I also consent to being performed on my child.

Side effects/Risks: I give this authorization with the understanding that any procedure may involve certain risks or hazards. There are minimal risks associated with sedation but may include dizziness, nausea, vomiting and rarely allergic reactions. Although very rare, more serious complications have been reported in the literature. We have not experienced any of the following in our office but they may include: infection, bleeding, pneumonia, aspiration, altered heart and breathing rate, and brain damage. To prevent these serious, possibly fatal consequences, your child will be monitored throughout the procedure. Our staff is trained in recognizing potential problems and we asked that your child remain in our treatment area under the care of a qualified staff member until he or she is safe to be discharged.

I, the undersigned, hereby acknowledge receiving a copy of the pre- and post-operative instructions which have been explained to me. I understand the advice given and agree to follow the care instructions closely. **I ACKNOWLEDGE THAT A CANCELLATION CHARGE OF $150 WILL APPLY IF VIOLATION OF THE PREOPERATIVE INSTRUCTIONS LEADS TO CANCELLATION OF THE SCHEDULED TREATMENT AND/OR IF I FAIL TO PROVIDE 48 HOURS NOTICE FOR CANCELLATIONS/CHANGES.** After discharge, I will notify Just4Kids if my child experiences any acute pain, heavy bleeding from any surgical sites, respiratory problems, or any other post-operative problems.

I have read this authorization and understand it and give my consent as above. I understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the words contained in the form.

_______________________________	_______________________________
Signature of Patient or Legal guardian	Relationship to Patient
_______________________________	_______________________________
Print Name	Date
_______________________________	_______________________________
Signature of Witness	Date