

DECLARATION for INFORMED CONSENT FOR PROVIDING PEDIATRIC DENTAL ASSISTANCE

I hereby authorize dental doctors from dental clinics Medstrom and / or dental care staff at their discretion to provide the following dental treatments or oral procedures to my child including the use of appropriate local or recommended anesthesia, radiography or diagnostic aid.

- A) Cleaning of teeth and local fluoride application
- B) Plastering of dentures / tooth grooves
- C) Treatment of sick or injured teeth with restorations (fillings)
- D) Replacement of missing teeth with dentures
- E) Elimination (extraction) of one or more teeth
- F) Treatment of diseased or injured oral tissues (hard and soft)
- G) Use of physical restraint or limiting devices to safely perform the necessary dental procedures.
- H) Postponing or delaying treatment at this stage
- I) Treatment of poorly positioned teeth and / or oral development or abnormal growth

I understand that there are treatment-related risks and I hereby confirm that these risks have been explained to me. I had the opportunity to ask my questions about the treatment and the risks involved, and I fully understand them.

I agree to the use of local anesthesia or the use of nitrous anesthesia at the discretion of doctors. I understand that nitrox may in some cases cause nausea and vomiting. I am also aware that the nosepiece leaves round traces around the nose that disappear soon after the procedure.

The present treatment was explained to me. Alternative methods of treatment, if there are such, have also been explained to me, as well as the advantages, disadvantages and risks that each one has. I was advised that despite the good results expected, the possibility and type of complications could not be accurately supposed. For this reason, no guarantee, expressed or implied, about the results of the treatment or the medication could be given.

I realize that during the course of treatment, unexpected circumstances may require the carrying out of additional or different procedures. For this reason, I authorize and resolve any additional procedures that are recommended or necessary for the good condition of my child's oral health, according to the professional conclusion of dental practitioners from Dental Clinics Medstom.

I understand and I have been informed that risks and complications may arise with the application of local anesthesia, sedatives and narcotic drugs. The most common are: swelling, bleeding, pain, nausea, vomiting, bruising, numbness and tingling of the lips, gum, face and tongue, allergic reactions, hematoma (swelling and bleeding around the injection site), fainting, burning of the lips cheeks as a result of inflammation and infection of the lining. I also understand that there is a rare risk of adverse drug reactions to respiratory and cardiovascular activities (stopping breathing and heartbeat) and that the lack of oxygen in the brain can cause coma or death.

I am aware that in some cases it is extremely difficult to treat a child due to the lack of cooperation. This is a relatively common young and old age situation with children with physical and / or mental disabilities that reduce their chance to fully cooperate in procedures and with children who are cowardly and nervous. I hereby authorize the use of an "Indian Board", the use of an oral support and the participation of a medical assistant for the care of the child if, during the treatment, at the discretion of the doctor, the safety of the child requires so.

Date:

Patient:

/first and last name/

Parent/ Legal guardian:

/signature/