4080 Lafayette Center Dr
Suite 160B
Chantilly VA, 20151
Ph: 403-203-1000
Fax: 703-230-0509

12700 Black Forest Lane
Suite 304
Woodbridge, VA 22192
Ph: 703-670-1991
Fax: 571-285-2972

Mala A. Britto, DDS, MS
Board Certified Pediatric Dentist

INFORMED CONSENT FOR PEDIATRIC DENTAL TREATMENT

Before we begin treatment, we request your permission to do the following procedures:

_____ Dental examinations
_____ x-rays
_____ Dental cleanings
_____ Fluoride applications

We also require your permission to perform the following dental treatment:

_____ Sealants (preventive, protective coating)
_____ Composite fillings (white fillings)
_____ Stainless steel crowns (silver crowns)
_____ Esthetic crowns (white crowns)
_____ Pulp treatments (indirect or direct pulp capping, pulpotomy, pulpectomy, root canal treatment)
_____ Dental Appliances (space maintainers, distalizing appliances, habit appliance, bite correction)
_____ Extractions
_____ Local anesthetic administration
_____ Nitrous Oxide use
_____ Mouth prop, rubber dam or Isolite use
_____ Dental laser use
_____ Frenectomy, Gingivectomy, Operculectomy
_____ Other_____

The purpose of these procedures is to restore and maintain dental health, and we expect positive results, although no guarantees as to the results may be given.

RISKS: Rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling and infection, early loss of teeth, objects lodged in the trachea or swallowing of objects, soft tissue trauma, loss/broken appliance and loss/broken tooth or filling.

I understand that I may refuse any or all of the above treatments recommended. However, ignoring a dental problem has an even greater risk namely abscess, infection, pain, fever, swelling, risk to the developing adult teeth, future orthodontic and gum problems, and rarely death.

After reading and understanding the diagnosis, prognosis, benefits, risks and alternatives of dental treatment recommended above, I authorize the doctors and staff working at Britto's Children's Dentistry to perform the above treatments checked off in this consent form.

This consent will remain effective unless withdrawn in writing by the person who has signed on Behalf of this minor patient.

CHILDS NAME: _____

PARENT/GUARDIANS NAME: _____ SIGN: _____

RELATION TO CHILD: _____

STAFF SIGNATURE: _____ DATE: _____

www.drbritto.com
Email : frontdesk4drbritto@Gmail.com