Treatment Consent Form

I give my consent for treatment that includes but not limited to cleanings, exams, fluoride treatments, and radiographic images.

I give my consent to Dr. Patrick Wilson and his staff to repair my child's decayed teeth with any materials and procedures they deem necessary. Dr. Wilson will review all treatment plans before the treatment appointment, but I understand the plan can change during treatment depending on clinical findings. Any changes will be discussed during the appointment as well as possible depending on the clinical situation.

I understand that treatment plans for any type of treatment under anesthesia (sedation/general anesthesia) are estimates of work that needs to be done. New radiographs (x-rays) during the sedation appointment often led to finding more decay, which necessitates more restorations than previously planned. Some teeth may not be restorable, and my need to be extracted (taken out). The dental disease will all be addressed while the patient is sedated, and it is not possible to discuss additional findings until after Dr. Wilson has completed treatment.

Thanks for placing your child in our care. We work hard to prevent and resolve all your child's dental needs in a comfortable environment.

Patient Name: ________________________________ DOB: _______________

Signed: ________________________________ Date: ________________