Saskatoon Pediatric Dentistry

INFORMED CONSENT FOR DENTAL PROCEDURES

I hereby authorize Dr. Anjani Koneru and/or employees who are working with her to perform the following dental procedures upon _____ as previously explained
(Patient Name)
to me, or other procedures advisable as necessary to complete the planned operation:

☐Dental Examination
☐Polishing/Scaling
☐Sealants
☐White Fillings
☐Periodontal Services
☐Amalgam Fillings
☐ Crowns
☐Fluoride Treatment
☐X-rays
☐Veneers
☐Bleaching
☐Nerve Treatments (pulpotomy)
☐Root Canals
☐Extractions
☐Sedation
☐Local Anesthesia
☐Lab Tests
☐Space Maintainers
☐General Anesthesia

I understand the risks and benefits of the above selected procedures. I also acknowledge that I am aware of alternative treatment choices and that they have been explained to me.

Potential Risks

- Pain, swelling, delayed healing
- Damage to and possible loss of other teeth or restorations
- Infection, abscess or ear or nasal problem requiring additional treatment
- Bleeding
- Loss of bone
- Jaw fracture
- Injury to nerve at treatment site causing temporary or permanent numbness, pain or tingling of lips, chin, face, mouth or tongue or loss of sense of taste.
- Restricted mouth opening for several days or weeks
- Decision to leave a small piece of root in jaw when its removal would require extensive surgery.

I am aware that in any procedure complications can develop that could leave my child/charge in a worse state than before the procedure.

I fully understand that Dr. Koneru has not, nor can guarantee that the procedure/treatment will last for any specific period of time.

I am aware that without treatment, my child/charge's present condition may worsen with time and the risks to my child/charge's health may include, but are not limited to the following; pain, swelling, infection, loss of function, cyst formation, malocclusion, premature loss of teeth, premature loss of bone.

I understand that this Consent to Treatment form will be governed by the laws of the Province of Saskatchewan and I consent to the courts of the Province of Saskatchewan having exclusive jurisdiction to entertain any action, suit or proceeding in respect of, or in any way relating to, such treatment.

I confirm that I have discussed the method and terms of payment for the selected treatment described above with Dr. Koneru or her staff and that I have agreed to make payment on the terms we discussed.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS REFERRED TO WERE IN FACT MADE TO ME AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT.

_____ _____ _____

Signature of Patient, Parent or Legal Guardian | Signature Witness | Date