TEXAS CHOICE DENTAL

PULPOTOMY INFORMED CONSENT

This form and your discussion with your child's doctor are intended to help you make an informed decision about your child's procedure. As a member of the treatment team, you have been informed of your child's diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. In order to increase the chance of achieving optimal results, you have provided your child's complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable). Your doctor will be happy to answer any questions you or your child may have, and provide additional information before you decide whether to sign this document and proceed with the procedure.

I have been informed of and understand the potential risks related to this procedure include but are not limited to:

- Varying lengths and degrees of sensitivity, bleeding, infection, gum irritation, numbness that may be permanent, risk of tooth fracture, damage to adjacent teeth, cracking and/or stretching of the corners of the mouth, stress to the jaw joints (TMJ), altered bite, instrument separation, possible breakage/dislodgement/bond failure of material, change in aesthetic appearance of teeth, allergic and/or adverse reaction to medications and/or materials.
- This procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had a pulpotomy may require re-treatment, Root Canal Therapy or tooth extraction.

I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

- Allergic or adverse reactions to medications or materials, pain at the anesthesia injection site, bruising/swelling, nerve injury, nausea, vomiting, disorientation, confusion, lack of coordination, drowsiness, heart and breathing complications, numbness following anesthesia that in rare instances may be permanent, overdose.

I further understand that the use of protective stabilization may be become necessary in the interest of safety for the patient, staff, or guardian. Protective stabilization may include: mouth prop, the use of a stabilization board, fabric wraps, Velcro® materials, or being restrained by a parent, guardian, and/or dental staff member. Possible risks and complications that have been explained to me include: distress and/or chance of injury including bruising or skin abrasion.

I have been informed of and understand that follow up visits or care, additional evaluation and/or treatment may be needed.

Patient's Responsibilities

I agree to have my child follow all instructions provided to us by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my child's doctor of any post-operative problems as they arise. Our failure to comply could result in complications or less than optimal results.

I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

_____

Patient's Name

_____ _____

Patient's (or Legal Guardian's) Signature Date