noble
PEDIATRIC DENTAL
Gentle Care From the Start

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DENTAL TREATMENT CONSENT - *WHITE CROWN*

I, the undersigned parent, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my child's dental condition and have discussed several treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions. I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my child's health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

☐ **COMPOSITE (WHITE) CROWN** tooth#_____
If a front tooth is badly destroyed a filling will not stay in place. The tooth is trimmed around the sides and a crown is placed over the tooth to protect it from breaking. This crown will stay in place until the tooth is ready to come out naturally. A local anesthetic will be used that will numb the area for 1-2 hours.

_____ _____ _____
Child's Name **Responsible Party's Signature** **Date**

_____ _____
Attending Dentist Signature Staff Signature