

# Consent Form: Dental Treatment

## Under General Anesthesia / Conscious Sedation For Children

Dental treatment under general anesthesia / conscious sedation\* is performed in children requiring extensive or complex dental treatments and/or in young children and/or children who are incapable of cooperating.

I, the undersigned \_\_\_\_\_  
Last Name First Name I.D.

Father/mother/ guardian of the child named:

\_\_\_\_\_  
Last Name First Name I.D. (Hereinafter: "the Child").

Hereby declare and confirm that I received detailed verbal explanation from:

Dr. \_\_\_\_\_  
Last Name First Name

### Regarding the need to perform dental treatment under general anesthesia / conscious sedation\*.

Details of the treatment:

\_\_\_\_\_  
(Hereinafter: the "Principal Treatment").

I confirm and agree that the Child would undergo dental treatments under general anesthesia / conscious sedation\*, after I was informed of the essence of the Principal Treatment including, the anticipated results, the chances and risks involved and after considering the possible alternative treatment techniques under the circumstances of the case.

It was explained to me about the side effects of the Principal Treatment, including pain, discomfort, swelling, infection, sensitivity to coldness and heat and temporary limitation in mouth opening.

In signing this document, I confirm and agree to the performance of the dental treatments specified in the treatment plan, which had been presented to me prior to the treatment. Nevertheless, it was clarified to me that it may become necessary to change the treatment plan due to unexpected findings that could not be predicted in advance and that may be detected for the first time during the treatment or following the performance of an x-ray during the planned dental treatment.

I agree that the planned treatment will be performed while the Child is under general anesthesia / conscious sedation\*, including operative dental treatments, extraction of hopeless teeth as well as additional treatments that will become necessary according to clinical and radiological findings detected during the treatment.

I understand the importance of providing accurate information concerning the health condition of the minor and of following all the instructions given to me by the treating staff/physician, including maintenance of oral hygiene.

I hereby declare and confirm that I received explanation from an anesthesiologist about general anesthesia / conscious sedation\*.

\_\_\_\_\_  
Name of Guardian (relationship)

\_\_\_\_\_  
Guardian's Signature (When patient is legally or mentally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian all the aforementioned in the required details and that he/she signed the consent before me, after I was convinced that he/she fully understood my explanation.

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
License No.

\*The explanation and signature on this form do not eliminate the need to provide separate explanation and to sign a separate consent form for anesthesia and/or conscious sedation..

