

**INFORMED CONSENT FOR ROUTINE DENTAL CARE WITHOUT SEDATION**

This is to authorize the provision of routine dental treatment that is deemed necessary for

\_\_\_\_\_ by the Dental Staff of SEVTC. I understand that routine dental treatment often necessitates the use of anesthesia or sedatives, as well as a medical restraint device to assist the dental procedure, and I authorize the use of these medications and or medical restraint. It is understood that elective dental surgery will not be performed without consulting me and obtaining my written permission.

Routine dental care consists of:

- |                                                           | <u>Circle One</u> |    |
|-----------------------------------------------------------|-------------------|----|
|                                                           | Yes               | No |
| a) Prophylaxis: (cleaning of teeth)                       | Yes               | No |
| b) Diagnostic Dental x-rays                               | Yes               | No |
| c) Restorations (filling of cavities & cosmetic fillings) | Yes               | No |
| d) Extractions (pulling teeth for the following reasons)  | Yes               | No |
| • abscessed teeth (infected teeth)                        |                   |    |
| • teeth extremely loose causing pain                      |                   |    |
| • teeth too broken down to be restored                    |                   |    |

At this time the SEVTC Dental Clinic is unable to provide complex extractions requiring an oral surgeon, crowns (caps), bridges to replace missing teeth, or partial and full dentures. I understand that once a tooth is extracted at this clinic there are currently no provisions for replacing these teeth with prostheses as stated above at this Facility. Referrals will be provided upon request.

In the event of an emergency, every effort will be made via telephone to contact me and I have provided my contact telephone number below. However, in the event I cannot be reached, this form is to serve as authorization for SEVTC dental/medical staff to arrange for and/or perform whatever emergency dental and/or surgical treatment (including the use of anesthesia) is considered necessary. I also consent to the disposal (by personnel or agents acting for SEVTC) of any tissues or parts which may be removed in an operative procedure.

\_\_\_\_\_  
Signature of client/parent/guardian/AR

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of above signature

(\_\_\_\_\_)\_\_\_\_\_  
Emergency contact number