Aquia Dental Care

Norma D. Gutierrez, D.D.S.

Consent For Treatment Without Parent

(14 Years Old and Older)

At Aquia Dental Care, we understand that from time to time you may not be able to bring your child to their dental appointment. We will treat your child without you being present for any all dental procedures provided that:

1. The child is 14 years old or older.
2. The parent/legal guardian is available by telephone.
3. The parent/legal guardian has signed all required documentation.
4. The parent/legal guardian has informed our office that they will not be present during the appointment before their child comes in for their appointment.

Minor children who are able to drive themselves to their appointments must bring in written documentation from their parent/legal guardian giving permission to Aquia Dental Care to perform any and all dental procedures.

Virginia law assumes consent to emergency treatment has been given. As such the doctor should proceed in calling local emergency services if needed. In the event of an emergency or unexpected incident occurs, it is imperative that the parent/legal guardian be reachable by telephone.

Please review & sign the form below giving us permission to treat your child/children without a parent/legal guardian present.

Permission To Treat

(Please Print Clearly)

I, _____, hereby authorize and direct the dentists of Aquia Dental Care and dental staff to perform all dental treatment for my child, _____, including the use of any necessary or advisable local anesthesia, diagnostic radiographs (x-rays) or diagnostic aids and the following:

1. Cleaning of teeth and the application of topical fluoride.
2. Application of plastic "sealants" to the grooves of the teeth.
3. Treatment of diseased or injured teeth with dental restorations (fillings).
4. Replacement of missing teeth with dental prosthesis.
5. Removal (extraction) of one or more teeth.
6. Treatment of diseased or injured oral tissue (hard and/or soft).
7. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
8. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

I understand that there are risks involved in this treatment and hereby acknowledge that these risks have been explained to me, that I have had an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctors. I understand that nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure.

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This treatment has been explained to me. Alternate methods of treatment, if any have also been explained to me, as have the advantages, disadvantages and risks of each. I am advised that through good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee either expressed or implied, as to the results of the treatment or as to the cure.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to the child's oral health and well being in the professional judgment of the dentists of Aquia Dental Care.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping or breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

I am aware that it is sometimes extremely difficult to perform dental treatment on a child because of lack of cooperation. This is fairly common in very young and immature children, in those children with physical and/or mental handicaps which diminish their ability to cooperate fully with the procedures and in children who are fearful or anxious. I hereby authorize the use of a papoose board, the use of a mouth prop, and the assistance of a dental auxiliary in holding the child, if in the doctor's opinion, the child needs to be restrained during treatment for his/her safety.

I understand and agree to the Aquia Dental Care's Consent For Treatment Without Parent form and it's terms.

Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Relationship to Patient: _____ Patient Date of Birth: _____

Best Contact Telephone Number While Your Child Is In Our Office: _____

Alternate Phone Number: _____ Date of Appointment: _____

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