15500 W. Highway 71 • Suite 300 • Bee Cave, TX 78738 • (512) 900-2017 • LuvBraces.com

I, _____, consent for my child _____ to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, the patient may undergo the following dental procedures when deemed necessary including but not limited to: nitrous oxide administration, local anesthesia, extraction, endodontics (pulpotomy and pulpectomy), restorative dentistry (resin fillings and crowns), cleaning, fluoride treatment, radiography, space maintainers and related procedures in pediatric dentistry.

2. I will provide a thorough and complete medical history, supply a full list of the patient's medications with dosages, and consent to the dentist communicating with other medical practitioners to inquire about any aspect of my child's health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

5. The treatment plan may change at any time and I will do my best to approach my child's dental care with optimism and open communication with the dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my child's dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name **Date**

_____ _____

Witness **Date**