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

CONSENT TO CONSCIOUS SEDATION AND TREATMENT

Patient Name:_____ Date/Time: _____

Parent/Legal Guardian Name and Signature: _____

I authorize Dr. Matt Lucero of Luv Brace & Kid's Dentistry or his/her designee and such assistants as may be chosen by him/her to perform upon my child the following procedure, and/or treatment.

If any conditions are revealed or arise during the operation, procedure, and/or treatment in addition to or different from those now contemplated, I authorize the performance of such procedure or treatment without terminating the initial procedure or treatment. Furthermore, I authorize these additional or different procedures or treatments to be done without prior discussion with me.

The nature and purpose of the procedure and/or treatment, the risk involved and the possible complication and side effects, the risks and consequences of no procedure and/or treatment, possible alternatives to the procedure, and or treatment, have been fully explained to me. The material risk, complications and possible alternative are set forth below and have been discussed with me. I acknowledge and understand the results of the treatment, and or procedure are not guaranteed and that unpredictable complications might arise in addition to those discussed with me.

Alternatives to conscious sedation are restraining the patient, administration of nitrous oxide/oxygen, relative anesthesia or general anesthesia in the operating room. Electing not to have treatment may result in abscesses, damaging permanent teeth, pain and swelling causing space loss for permanent teeth or serious medical complications.

I authorize Dr. Matt Lucero of Luv Braces & Kid's Dentistry to prescribe and use such sedation agents as they may consider advisable in the procedure. The risks and complications of conscious sedation have been explained to me and the material risks and complications of conscious sedation are listed below. I understand the administration of medications may lead to unpredictable complications in addition to those discussed with me.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include but are not limited to: vomiting, numbness, discoloration, infection, aspiration, allergic reaction, breathing difficulties, or atypical psychological response that may even cause necessary hospitalization, further surgical procedures, disability and system impairment, nerve damage, brain damage, resulting in falling and subsequent injuries or death.

I as a parent/legal guardian consent to the collection of patient information and the taking and using of any photographs/video for the purposes of research and/or advancing medical/dental education provided that the patient's identity is not revealed by the patient information, photographs/video or any accompanying description. For the purpose of advancing medical/dental education, I consent to the admittance of authorized observers to the procedure. I also consent to the medically appropriate disposal of any tissue or teeth which may be removed during the procedure.

My signature below certifies that I have 1) read and fully understand the above consent; 2) this form has been fully explained to me; 3) that the proposed procedure, and/or treatment has been satisfactorily explained to me in language that I have understood; 4) that the risks, complications and alternative to the procedure and/or treatment have been explained to me in language that I have understood; 5) that all my questions have been answered and the explanations referred to in the above paragraphs were discussed with me; 6) that my child has had nothing to eat or drink in the last 6-8 hours.

Signature: _____

Relationship to patient:_____Date/Time: _____

Witness Signature: _____

Witness Printed Name: _____

Physician Signature: _____