REQUEST AND CONSENT FOR PEDIATRIC DENTAL TREATMENT

Please read this form *carefully*! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it!

1. I request and authorize the treatment and procedures (i.e. exam, x-rays, and/or cleaning) outlined on the PLAN OF CARE for:
   Patient Name: _____

2. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).

3. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include, but are not limited to the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

4. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's PLAN OF CARE and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledges that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in Dr. Merhoff and Associates office.

5. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

6. I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and/or parent to hold the patient's hands, stabilize the head and/or control leg movements.

7. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational, or research purposes.

8. All of my questions have been answered to my satisfaction and consent to the treatment and procedures prescribed for the patient on the PLAN OF CARE.

9. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

10. I confirm that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

_____ _____

Signature of Person Consenting to Treatment Date

_____ _____

Signature of Dr. Tina Merhoff Date

_____ _____

Witness Certification Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Tina S. Merhoff, DDS, PA "Notice of Privacy Practices", detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

I understand that I have the right to request restrictions concerning the use of my information. I request the following restrictions.

_____

_____

_____

_____ _____

Signature of Patient/Guardian Date

_____ _____

Relationship to Patient Witness