

**All Smiles Family Dental**  
**537 E Dundee Rd, Palatine, IL 60074**  
**Ph. 847-907-0585**

**Informed consent for Treatment of a Minor**

Dentistry is an important health service for your child, and it is our goal to provide him/her with a satisfying experience in our office. Please read this form carefully. Should you have any questions, our office staff will be happy to help you.

1. I hereby authorize and direct Dr. Pallam, Associates, and the staff of All Smiles Family Dental to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand certain parts of the treatment may be performed by certified paraprofessionals (dental assistants) other than the dentist.
3. I also authorize All Smiles Family Dental to take and to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publication. The photographs shall be used for dental records and if in the judgment of the staff, dental research, education, or science will be benefited by their use, such photographs and information relating to my child's case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which s/he may deem proper in the interest of medical education, knowledge, or research; provided however, that it is specifically understood that in any such publication or use my name or my child's name not be identified. The aforementioned photographs may be modified or retouched in any way that my dentist, in his/her discretion, may consider desirable.
4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request for a fee.
5. In general terms, the dental procedure(s) can include but not be limited to:
  - a) Comprehensive oral examination, radiographs, cleaning of the teeth and the application of topical fluoride.
  - b) Application of sealants to the grooves of the teeth.
  - c) Treatment of diseased or injured teeth with dental restorations, stainless steel or composite crowns, and/or root canal treatment.
  - d) Oral surgery, extraction of one or more teeth, excision of hyperplastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth.
  - e) Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
  - f) Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
  - g) Treatment of habits, malposed (crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities.
6. I authorize the use of accepted behavior management techniques including nitrous oxide analgesia in order to complete treatment for my child.
7. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.
8. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.
9. I have answered all the questions about my or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should receive oral medications and/or anti-anxiety agents. I will not hold Dr. Pallam or any of her staff responsible for any errors or omissions I may have made. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.
10. I authorize other individuals with whom I have placed the care of my child, such as other family members or caregivers, to sign consent for dental treatment for my child should they bring my child to any future appointments.
11. I authorize All Smiles Family Dental to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read & understand this consent & the meaning of its contents. All questions have been answered in a satisfactory manner & I believe I have sufficient information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Parent's or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient