Consent for Dental Treatment under General Anesthesia in the Operating Room at Sparrow Hospital

I, ______________________________ give consent for ________________________________________________ to 
Receive dental treatment under general anesthesia in the operating room at Sparrow Hospital.

☐ Dental Treatment will be provided by Dr. Jacob Myers

☐ The following dental services will be provided: Cleaning, x-rays, composite (white) fillings, baby root canals, silver caps space maintainers, tooth vitamins (fluoride treatment).

☐ I understand that it may be necessary to alter treatment plans based on findings during my child’s surgery. 
I grant Dr. Myers permission to provide alternative treatment and/or procedures necessary for my child’s oral health.

☐ Treatment, risks and alternatives have been reviewed with me and all of my questions have been answered.

☐ All patients undergoing general anesthesia are subject to risk of medical complications including, but not limited to: Sore throat, nausea and vomiting, respiratory and cardiovascular problems, malignant hyperthermia and death.

☐ If medical treatment becomes necessary, it will be provided by your child’s physician or a member of the Sparrow hospital staff. The parent or guardian is financially responsible for this treatment and any hospital or anesthesia charges not covered by insurance.

☐ I understand that this time is set aside for my child and that if I am unable to keep this appointment I will be charged a $______ hospital fee not covered by my insurance.

Person signing form: ☐ Mother ☐ Father ☐ Legal Guardian

_________________________________________  ___________________________  ___________________________
Signature                  Printed name                  Date

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