



PEDIATRIC DENTISTRY

2121 Abbot Road • East Lansing, Michigan 48823 • 517.337.0032
Fax: 517.337.8983 Email: yourchildsdds@gmail.com www.yourchildsdds.com

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

