GOEBEL
PEDIATRIC DENTISTRY

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Oral Rehabilitation under General Anesthesia Informed Consent
Dental Procedures/Treatment

1. I hereby request and authorize Dr. Goebel to perform upon _____
   Name of Patient

   the following procedure: oral rehabilitation under general anesthesia including any or all of the following: oral exam, prophylaxis (cleaning), x-rays, fluoride application, sealants, restoration of carious teeth with amalgam (silver) fillings, composite/resin (white) fillings, stainless steel crowns of posterior (back) teeth, stainless steel crowns with or without composite window facings of anterior (front) teeth, pulp therapy, extraction (removal) of non-restorable teeth, clinical photographs, placement of space maintainers, and other dental treatment deemed necessary upon examination of the patient.

2. I understand that during the course of the procedure, unforeseen conditions may arise which may necessitate procedures different from or in addition to those contemplated. I, therefore, consent to the performance of additional procedures that the dentist deems necessary.

3. The nature of the patient's condition, the nature and purpose of the operation/procedure, possible alternative methods of treatment, the risks involved, and possible consequences and complications have been explained to me.

4. In the event developments indicate that further operations/procedures may be necessary, I authorize the doctors to use their own judgment and do as they deem advisable during the operation/procedure for the patient's best interest.

5. I am aware that the practice of dentistry, medicine, and surgery is not an exact science and acknowledge that no guarantees have been made to me by anyone concerning the results of the aforementioned operation/procedure.

Signature: _____ Date: _____
Patient/Parent/Legal Guardian

Print Name: _____ Relationship to Patient: _____

Patient Name: _____ DOB: _____

Witness: _____