Wright Smiles
Pediatric Dentistry

**CONSENT FOR TREATMENT WITH ORAL SEDATION**

The purpose and nature of the dental treatment have been fully explained to me. I have been informed of and fully understand all risks that are involved in the performance of the treatment and sedation to be rendered. I fully understand there is a possibility of medical complications developing during or after the procedure and that these may include adverse reaction to a drug, or a typical physiological response that may cause necessary hospitalization, further surgical procedures, disability, any system impairment, permanent or temporary nerve damage, brain damage or death.

I am giving my full and informed consent for the treatment to be rendered as described to me. I have no further questions about any of the procedures or treatment. I have not been given or received any guarantees as to treatment or sedation my child, _____ is to receive.

I am aware that there will be sedation administered, and of the above outlined risks, as well as any other risks outlined by the doctor. I understand that it may be necessary to hold my child's hands to prevent injury to my child during treatment. I also understand that treatment will stop and Dr. Jody Wright will discuss an alternative treatment method if my child is not responding well to the oral sedation. I do give my free and voluntary informed consent.

**Date** _____ / _____ / _____ **Signature:** _____

**Relationship:** _____

**Witness:** _____

**Jody L. Wright, DDS., Inc.**

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**www.wrightsmilespediatricdentistry.com**