KIDS DENTAL
Dr. Lisa Lazzara
BOARD CERTIFIED PEDIATRIC DENTIST
Helping infants, children of all ages, teens, and those with special needs

4864 Arthur Kill Road
Staten Island, NY 10309
(across from Regional Radiology)
718-356-KIDS (5437)

1839 North Railroad Avenue
Staten Island, NY 10306
(corner of Guyon Avenue)
718-667-KIDS (5437)

www.sidentist4kids.com

CONSENT FOR TREATMENT

We would like to welcome you and your child to our office. It is important that we inform you about the various procedures provided in Pediatric Dentistry. Informed consent is necessary before starting your child's treatment. Please take a moment to carefully read this form. Since, ____________________(**Patient's Name**) is a minor, it is necessary that signed permission be obtained from parent or legal guardian before any dental services can be started and accomplished by Dr. Lisa Lazzara or any other doctors, hygienists, assistants, or staff associated with Kids Dental, P.C. and Kids Dental of Staten Island, P.C.

Authorization is hereby granted to perform examinations, take x-rays and/or photographs, clean teeth, administer fluoride treatments, and provide oral hygiene instruction if deemed necessary.

After thorough examination, if further treatment is necessary, authorization is hereby granted to administer local anesthetics and/or nitrous oxide analgesia and perform any treatment (i.e. x-rays, photographs, cleaning, sealants, white or silver fillings, pulp therapy, composite crowns, stainless steel crowns, extractions, space maintenance, tooth movement) and/or such operations, or treat my child as it may be deemed necessary or advisable by Dr. Lisa Lazzara or any other doctors, hygienists, assistants, or staff associated with Kids Dental, P.C and Kids Dental of Staten Island, P.C. I also give permission to provide my child with emergency care if needed. I have had the treatment plan(s) for my child explained to me. The risks involved with those procedures, alternatives to those procedures, risks therein involved, and the risks of no treatment at all have also been explained to me, and I understand the explanations. I have been given the opportunity to ask questions and have those questions answered.

Unless otherwise requested. we will use white/composite fillings. In some cases, the co-pay may be slightly higher than the silver/amalgam fillings.

_____ I request white/composite fillings for my child

_____ I request silver/amalgam fillings for my child

_____ I request white/composite fillings for adult (permanent) teeth and silver/amalgam fillings for baby (primary) teeth for my child

I authorize my child's pediatrician or other physician(s)/medical facilities to release any and all pertinent medical information regarding my child, I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references. I authorize transmission, electronically or other means of data for payment/communication purposes including, but not limited to, insurance companies

I hereby acknowledge that I have read and understand this consent form, and this consent shall remain in effect until I choose to terminate it and I will give written notification to reverse this document.

Print Name (Parent/Legal Guardian) __________________________ Date: _______________

Signed Name (Parent/Legal Guardian) __________________________ Witness: ________________

EMAIL ADDRESS: _________________________________

FOR OFFICE USE ONLY

Email Treatment Plan __________________ Next Visit ______________________________

Record Request ________________________ Sedation/Hospital Case __________________