Kids Plus Pediatric Dentistry, P.C.

PATIENT'S NAME_____DATE OF BIRTH_____

I, _____parent of _____, hereby
(print name) (print name)
authorize Dr. _____, to use the following type of restraints during
(print name)
the dental treatment of my above named child.

Type of restraint considered:

_____
_____

The use of and types of restraint listed above have been fully described to me. I understand that restraint may be necessary to protect my child and/or the dental staff from injury while providing dental care. I understand that restraint will be used only if my child cannot cooperate due to lack of maturity or mental/physical handicap and only when absolutely necessary. The dentist, staff, or parent with or without the aid of a restraining device can perform restraint. Physical restraint can be performed using hands, belts, tapes, sheets, papoose board, or head and jaw stability devices.

I further understand possible consequences or injury to my child's dental health if the restraint is not used.

I have been informed about alternative methods that are available to provide dental care for my child, including the provision of dental care without the use of restraint.

I have discussed that above with the doctor and have had the opportunity to have my questions answered.

_____
Parent/Guardian Signature Date

_____
Dentist's Signature Date

_____
Witness's Signature Date