Sprout Pediatric Dentistry & Orthodontics
Dr. Shaun Thompson-Banks
9025 N. Sam Houston Pkwy, Suite160
Humble, TX 77396
713-775-2888

GENERAL CONSENT FOR TREATMENT

My signature confirms that I have been informed by Dr. Shunda Thompson and/or persons on her staff regarding my oral treatment needs:

- Diagnosis
- Treatment and alternatives
- Advantages and Disadvantage of each alternative
- Risks, if present
- Result(s) of doing nothing at all regarding my oral treatment needs

The following treatment and work to be done as indicated below was agreed upon:

Initials:

TOOTH RESTORATION (FILLING):
_____ Tooth-Color (composite) restoration
_____ Amalgam (silver) restoration
DENTURES (REMOVABLE PROSTHODONTICS):
_____ Complete Dentures
_____ Immediate Temporary Dentures
_____ Removable Partial Dentures
PERIODONTAL TREATMENT:
_____ Debridement (Soft Tissue Management – STM)
_____ Root Planning and Scaling
_____ Periodontal Maintenance every _____ Months
_____ Cracked Tooth Syndrome Treatment

Initials:

_____ CROWNS, BRIDGES, STEEL CROWNS
_____ ENAMEL RESHAPING
_____ ENDODONTIC TREATMENT (Root Canal Therapy RCT)
_____ PULPOTOMY, INDIRECT PULP CAP
_____ NITROUS OXIDE/LAUGHING GAS
_____ TOOTH SEALANTS
_____ TEETH WHITENING
_____ SPACE MAINTAINER
_____ TOOTH EXTRACTION
_____ OTHER:_____

I understand that antibiotics (interferes with effectiveness of contraceptives), analgesics and other medications can cause allergic reactions.

By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information and that all of my questions have been answered fully and satisfactorily. I also understand the fees involved. Finally, I understand the possibility of an unsuccessful outcome in the event of inadequate follow-up with the dentist and hygienist and inadequate home care.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations. For example, root canal therapy following routine restorative procedures.

Understanding this, I give my permission and I hereby authorize the above-named dentist to make any/all changes and additions as necessary and to provide the above mentioned treatment and service(s).

Signature of Patient or Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Signature of Staff Person: _____ Date: _____