

Mission:
To protect, promote & improve the health
of all people in Florida through integrated
state, county & community efforts.



Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the Healthiest State in the Nation

Florida Department of Health in Nassau County Dental Clinic Consent Form

Patient's Name: _____
Last First M

Address: _____ City/State: _____ Zip: _____

Telephone Number: _____ DOB: _____

Social Security Number: _____ Sex F M Race: _____

Whenever medical or dental treatment is performed, there is always a risk of complications due to unexpected problems. In dentistry, some of the risks include, but are not limited to: Allergic reactions to the drugs and medications used, excessive bleeding, temporary or permanent numbness, and fracture of the jaw, post-operative pain or joint pain. Frequently, a child who is experiencing a lip that is "asleep" from the anesthetic may chew on his/her lip. If this does happen, try not to worry. It will heal quickly and without a scar. The occurrence of these reactions is rare, but you should know that sometimes they do occur.

If there is any treatment you do not want your child to have, please note it here: _____

(Understand that refusal of any recommended treatment may compromise the staff's ability to deliver **quality care**).

I HAVE READ, UNDERSTAND AND ACCEPT THE RISKS AS OUTLINED ABOVE. I give my consent for my child I myself to receive dental treatment from the staff of the Florida Department of Health, Nassau County Dental Clinic. In addition, I consent to have released to the dental program any medical chart information from any source concerning my child's I my physical or psychological condition to be used to provide better dental care.

Patient/Parent or Guardian of Patient Signature Date

Emergency Number: _____

CONSENT TO USE NITROUD OXIDE

Due to a patient's concern regarding a procedure, we sometimes us Nitrous Oxide anesthesia (laughing gas) to help relax patients. It does not put them to sleep. We use this only when care cannot be completed due to the child's anxiety.

I Consent to the use of Nitrous Oxide anesthesia, if necessary, during my child's dental treatment.

Patient/Parent or Guardian of Patient Signature Date