

PATIENT NUMBER

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(800) 243-4675

PATIENT'S NAME _____

Last

First

Initial

Date of Birth

I (print name) _____

(print name) _____

Dr. (print name) _____

parent of

hereby authorize

to use the

following type of restraints during the dental treatment of my above named child.

Type of restraints 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, tape, 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 the above with the doctor and have had the opportunity to have my questions answered.

Patient or Guardian's Signature

Date

Dentist's Signature

Date

Witness's Signature

Date

CONSENT FOR THE USE OF RESTRAINT(S)

Copy Courtesy of The Dental Record
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