Consent for Dental Treatment under General Anesthesia in the Operating Room

I, _____, Give consent for _____
Parent or Legal Guardian Name Patient's Name

To receive dental treatment under general anesthesia in the operating room at St. Margaret Mercy Hospital in Hammond, Indiana.

Dental treatment will be provided by Dr. Halum and assistants.

I understand that it may be necessary to alter the treatment plan during surgery and I give permission to provide alternate and/or additional procedures as deemed necessary by Dr. Halum.

The nature of the dental treatment, the risks, and the alternatives have been explained to me and also the refusal of dental treatment.

All patients undergoing **general anesthesia** are subject to risk of medical complications including, but not limited to: sore throat, nausea, vomiting, respiratory, cardiovascular problems, malignant hypothermia, and even death.

If medical treatment becomes necessary, it will be provided by your child's physician or a member of the hospital staff. You, the parent or guardian, are financially responsible for this treatment.

I understand and have had ample opportunity to discuss all of the above information. My questions have been answered, I know the risks, and I understand that the procedure cost may be my responsibility. I request treatment for my child.

If for some reason you need to cancel a surgery we require a **48-hour notice**. You must contact Dr. Halum's office at 924-5437. **DO NOT** contact the hospital to cancel. We will contact the hospital to inform them on any cancellations or changes regarding surgery. If no notice is given we will consider you a failure. If you fail to attend a surgery we will no longer welcome you as a patient here at Dr. Halum's office.

I, Kurt M. Halum D.M.D. explained all of the above and have given instructions and expected time frame.

Signature: _____ Date: _____

Relationship to Patient: _____