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CONSENT FOR DENTAL TREATMENT

Patient's Name: _____ **Date:** _____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITITALING.

_____ 1. **TREATMENT**

I understand that I may have the following dental treatment performed: fillings, crowns, bridges, dentures, extractions, impacted tooth removal, root canals, mini implants, treatment of periodontal disease or other work deemed necessary.

_____ 2. **DRUGS AND MEDICATIONS**

I understand that antibiotics, analgesics, anesthetics, Nitrous Oxide, and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea, and vomiting or more severe allergic reactions. I have informed the doctor of any know allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ 3. **RISKS OF DENTAL ANESTHESIA**

I understand that pain, bruising, and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue, or associated facial structure can occur with "shots." About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if symptoms do not resolve.

_____ 4. **CHANGES IN TREATMENT PLANS:**

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Patient or Guardian Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

Witness' Signature: _____ **Date:** _____