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Family Dentistry
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CONSENT FOR DENTAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

PLEASE READ CAREFULLY. State law requires us to obtain your consent to your dental treatment. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your dental treatment, the associated risks, and options or alternatives, including no treatment. Also that we have answered all of your questions in a satisfactory manner. Ask about anything you do not understand. We will be pleased to explain.

Some risks (but not all) known to be associated with this procedure, including anesthetic administration are:

Stretching of mouth may result in crackling, bruising
Change in bite
Swelling and bruising which may necessitate staying home
Infection, inflamation, swelling, sensitivity and/or pain
Loss of function of an organ
Loss of function of face, arms or legs
Disfiguring scars
Parasthesia (permanent or transient numbness of the palate, cheeks, gums, teeth, lips, tongue, chin, face)
Loss of taste
Aspiration of objects
Fracture and breakage of jaw
TMJ dysfunction or worsening of TMJ condition
Trismus (jaw pain or difficulty opening mouth)
Failure of treatment to accomplish its purpose
Failure of wound to heal
Death
Brain Damage
Quadriplegia
Lose of Organ[s]
Swelling and bruising which may necessitate staying home
Bleeding which may be heavy enough to stop the operation
Infection, inflamation, swelling, sensitivity and/or pain
Instrument breakage or retained instrument fragment(s)
Breakage of roots or retained root fragments
Damage to teeth and bone
Nose and sinus involvement
Further surgery or treatment
Swallowing and/or aspirations of objects
Bacterial endocarditis
Injuries to adjacent teeth and/or hard or soft tissues

I have been informed of the probability of occurrence of each of the foregoing risks as the result of or in connection with the surgical or dental procedure contemplated herein.

I hereby authorize and direct the above named dentist with associates or assistants, to provide such additional services as they may deem reasonable and necessary including, but not limited to, the administration of any anesthetic agent, or services of the X-Ray department or laboratories, and hereby consent thereto.

I understand I should immediately notify the dentist of any suspected complication(s) that may arise, where further treatment or alternative treatment(s) may be discussed. I understand in this event there may be additional medical expenses involved not currently anticipated. I also understand the Dentistry is not an exact science and that the proposed treatment goals may not be attained.

I hereby state that I have read and understand the consent, all questions about the procedure or procedures have been answered in a satisfactory manner, and that all blanks were filled in prior to my signature. This consent form is valid until revoked by me in writing and I hereby wave any further disclosure of information.

Signature of Patient _____ Date _____
Signature of Representative _____ Date _____
Witness _____ Date _____

I certify that all blanks in this form were filled-in prior to signature and I explained them to the patient or his representative before requesting the patient or his representative to sign it.

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Signature of Dentist