Informed Consent to Treatment

Drugs and Medication
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
(Initial: _____)

Changes in Treatment
I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
I give permission to the dentist to make any/all changes and additions as necessary once they've been discovered and discussed.
(Initial: _____)

X-Rays
I understand x-rays are necessary for proper diagnosis and treatment.
(Initial: _____)

Fillings
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours, to avoid breakage. I understand that a more expensive filling nay be required d due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common aftereffect of a newly placed filling.
(Initial: _____)

Local Anesthetic
Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to; It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and is some rare cases, the numbness can be permanent is the nerve is injured. Infection, swelling, allergic, reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment.
(Initial: _____)

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction.
I consent to the proposed treatment.
(Initial: _____)

General Consent to Treatment

1) I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2) I understand x-rays, photographs, models of mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.

3) In general terms, the dental procedure(s) can include is not limited to:
   a. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of fluoride.
   b. Application of the resin "sealants" to the grooves of the teeth
   c. Treatment of diseased or injured teeth with dental restorations (fillings).
   d. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections.
4) I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health services.
5) I certify that is I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

6) I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependant or I have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

_____
Patient Name (Print)

_____
Patient or Parent | Guardian Signature

_____
Date