

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms the contemplated dental treatment is: Examination and delivery of necessary care which may include: Cleaning, fillings, root canal, crowns, bridges, oral surgery and periodontal therapy.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or premedication prior to dental care being rendered. Some of these risks/ complications are, but are not limited to, the following:

Infection	Death (in rare instances)
Injuries to adjacent teeth and/or hard or soft tissues	Retained root fragments
Bleeding	Swallowing and/or aspiration of objects
Failure of wound to heal	Failure of treatment to accomplish its purpose
Dry socket	Trismus (jaw pain or difficulty opening mouth)
Loss of teeth	Paresthesia or numbness of tongue, and/or mouth, and/or face
Incomplete removal of tooth	Fracture of mandible (lower jaw) or maxilla (upper jaw)
Loss of bone	Slough (unanticipated loss of hard and/or soft tissue)
Injury to adjacent structures	Opening between mouth and sinus or mouth and nose
Instrument breakage	
Allergic reaction to drugs	
Bacterial endocarditis	
Tooth or fragment in maxillary sinus	
Breakage of root(s)	

Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

ACKNOWLEDGMENT : PATIENT'S NAME _____

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid unless revoked by me in writing.

Date

Signature of patient or guardian