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General Informed Consent for Dental Procedures

You, the patient, understands that I have the right to accept or reject dental treatment recommended by my dentist and acknowledge that prior to consenting to the recommended treatment by signing below, I have been fully advised of and I have carefully considered the anticipated benefits and possible known risk of the recommended procedure, alternative treatments, or the option of no treatment, as they are presented to me.

I have been advised and I understand that individual reactions to treatment cannot be predicted, and by consenting to the treatment, I am acknowledging my willingness to accept all risk and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. I understand that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, at this office or with other recommended dentist or specialist, following all pre and post treatment instruction, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to this office any changes in my health status. I understand that failing to follow the advice of my dentist may increase the chance of a poor outcome.

Please read the items below, initial where indicated, and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following **MAY** be provided:

Examinations	Crowns and Bridges	Radiographs
Preventive Services	Root Canal Therapy	Other
Restorations	Extractions	

Patient Initials____________

2. Drugs and Medications

I have been advised and I understand that antibiotics, analgesics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reactions). I will inform the office of any such known reactions to the best of my knowledge. I have advised the dentist of any and all medication of any type that I currently am taking, and I acknowledge that my failure to advise the dentist may have unforeseen medical consequences for me.

Patient Initials____________

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3. Local Anesthesia

I understand that there are some risks in the administration of local anesthesia. Most risk are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they might include loss of, or disturbed sensation of the tongue and/or on the lip on the side of the injection. If this occurs, it is often temporary, and normal sensation usually returns in several days. However, in very rare cases, the loss of sensation may extend for a longer period or become permanent. In addition, injection of a local anesthesia into the body may result in a rare allergic reaction.

Patient Initials______________

4. Changes in Treatment Plan

I have been advised and 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 my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials______________

5. Insurance Communication

I give permission to the dental office to communicate with and bill my dental insurance provider for any treatment to me, if applicable.

Patient Initials______________

I understand that dentistry is not an exact science and that, reputable practitioners cannot Guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

____ Date____________________

(Signature of patient, parent, guardian or personal representative)

____ ____________________

(Please print name of patient, parent, guardian or personal representative) (Relationship to patient)