Whitaker
FAMILY DENTISTRY

GENERAL CONSENT FORM

PATIENT'S NAME _____
Last First Initial Date of Birth

I hereby authorize the Dentist and whomever he/she designates as his/her assistant, to perform upon me the following operation and/or procedures:

Cleanings, root planing, fillings, root canals, extractions, crowns, bridges, partial dentures, complete dentures and/or any other procedures deemed necessary from exams and x-rays per patient's approval.

I request and authorize the dentist to do whatever is advisable if any unforeseen condition arises in the course of treatment , in their judgment, requiring additional or different procedures from those originally contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local anesthetics, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthetic. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include postoperative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers and responsive explanations for all questions about my medical condition, contemplated any alternative treatments and procedures, prior to signing this form.

Patient or Guardian's Signature _____ Date _____