DENTAL TREATMENT CONSENT

I Hereby authorize Dr. _____ and such assistants as may be selected by any of them, to treat the condition(s) described below: _____

_____

_____

The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure to be: _____

_____

_____

I have been informed of possible alternative methods of treatment (if any).

I have further understood that this is an elective procedure and other forms of treatment or no treatment at all are all choices that I have and that this treatment (in my doctor's opinion) will provide the optimum relationship between teeth, jaws, muscles, and the temporomandibular (jaw) joint that is possible at this time.

The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and some of the operative and anesthesia risks include, but are not limited to the following:

A Post-operative/treatment discomfort and swelling, that may necessitate several days of home recuperation.

B Heavy bleeding that may be prolonged.

C Injury to the adjacent teeth and fillings, causing loss of a tooth or teeth or need for restorations or root canal therapy.

D Development of a dry socket — localized alveolitis — requiring extended treatment.

E Post-operative infection requiring additional treatment.

F Delayed healing requiring additional treatment.

G Stretching of the corners of the mouth with resultant cracking and bruising.

H Restricted mouth opening for several days or weeks.

I Decision to leave a small piece of root in the jaw when its removal would require extensive surgery or nerve damage.

J Breakage of the jaw.

K Swallowing of tooth; swallowing of tooth with tooth being lodged in the lung, requiring a chest x-ray and subsequent surgical removal.

L Injury to the nerve underlying the teeth resulting in numbness, tingling, painful or altered sensation in the lip, chin, cheek, gum, teeth, and/or tongue on the operated side; this may persist for several weeks, months or in remote instances, permanently.

M Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery. A sinus infection may develop, or loss of a piece of tooth or whole tooth in the sinus requiring recovery.

N Stiff neck or facial muscles.

O Changes in the bite or pain of the Temporomandibular joint (ear/jaw joint).

P If intravenous medication is used, soreness at the injection site or along the vein may develop as well as some discoloration of the injection site (thrombophlebitis). This may require further surgical treatment.

Q Allergy to drugs used may cause an anaphylactic reaction resulting in paralysis, brain damage, or death.

R Cardiac arrest or stroke.

S Other:_____

_____

It has been explained to me that, during the course of the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in above. I therefore authorize and request the persons described in paragraph 1 above to perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known at the time of the original procedure is commenced.

I consent to the administration of anesthesia, including local anesthesia, nitrous oxide analgesia, intravenous, and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described above, and to the use of such anesthetics as may be deemed advisable with the exception of: _____
to which I said I was allergic. *(none or name of particular anesthetic)*

Medications, drugs, anesthetics and prescriptions may cause drowsiness, lack of awareness and coordination, and nausea, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

I understand that I may not have anything to eat or drink for eight (8) hours before surgery under IV sedation/general anesthesia (unless otherwise instructed).

I have had ample opportunity to seek other opinions attendant to my care.

I certify that I read and write English and have read and fully understand this consent for treatment. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

Do not sign this form unless you have read it, understand it, and agree with what it says.

_____
Patient's Signature Date

_____
Parent or Legal Guardian (If under 18) Date

_____
Witness (Professional staff member) Date