Consent to Perform Dentistry

Patient Name:_____ _____
Date:_____
I hereby authorize and direct the dentists of_____to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.These procedures include, but are not limited to examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, and extractions.

I understand that there are risks involved in this treatment and hereby acknowledge that these risks have been explained to me, that I have had an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctors.

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages and risks of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorized and request the performance of any additional procedures that are deemed necessary or desirable.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa.

Patient's signature Date

Dentist's Signature Date