Dr. Byron R. Rome D.D.S.

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 and we are ready to answer any of your questions or explain anything.

Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms, the contemplated dental treatment is: General Dental procedures

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There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic 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
Bleeding
Failure of wound to heal
Injuries to adjacent teeth and/or hard or soft tissue
Paresthesia or numbness of: Tongue, and/or mouth, and/or face
Fracture of mandible (lower jaw) or maxilla (upper jaw)
Opening between mouth and sinus or mouth and nose
Tooth or fragment in maxillary sinus
Incomplete removal of tooth
Dry socket
Loss of teeth
Loss of bone
Slough (unanticipated loss of hard and/or soft tissue)
Injury to adjacent structures
Instrument breakage
Breakage of root(s) and retained root fragments
Swallowing and/or aspiration of objects
Allergic reaction to drugs
Truisms (Jaw pain or difficulty opening mouth)
Failure of treatment to accomplish its purpose death (in rare instances)
Bacterial Endocartis
Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

ACKNOWLEDGMENT

I acknowledge that I have read, or that it has been read to me, and 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 will remain valid until revoked by me in writing.

Print Patient Name Signature of Patient or Guardian Date