



CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law required 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

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 Endocarditis
- Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s)

ACKNOWLEDGEMENT

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.

Printed Patient Name

Signature of Patient or Guardian

Date