

General Dental Treatment Consent Form

Date of Birth: _____/_____/_____ **Name:** _____

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.

In general terms, dental treatment may include but is not limited to one or a number of the following:

- Administration of local anesthesia
- Cleaning of the teeth and application of topical fluoride
- Scaling and root planing (SRP) with local anesthesia
- Application of sealants to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations

Risk of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms. Temporomandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my conditions does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Alternative Treatment

I understand that I have the right to choose, on the basis of adequate information, from alternative treatment plans that meet professional standards of care.

By signing below, I consent to the general treatments and/or proposed treatment.

Printed Name of person signing for Patient: _____

Signature: _____

Patient Name (Printed): _____

Date: _____