Flora Stenger D.D.S.
Carol Basilio D.D.S.
Oliver Hoffman D.D.S. - Periodontist
Farah Abbassi, D.M.D . M.S.D. – Endodontist
Namid Z. Baba, DMD, MSD, FACP - Prosthodontist

Consent for Treatment

Please Read Before Signing

Patient's Name _____

Last Name **First Name** **Initial** **Date of Birth**

I hereby authorize Dr. Flora Stenger,

And whomever she may designate as their assistant and associate dentists, to perform upon my required services, operations and/or procedures initially discussed and listed in the treatment record. I understand they are only tentative treatment plans based on the initial exam, and that changes may occur as services are rendered.

I request and authorize the above to do what they deem necessary if any unforeseen condition arises in the course of these designated operations and/or procedure calling in their judgment for procedures in addition to or different from those initially contemplated.

I consent to the administrator of local anesthesia, antibiotics, analgesics or any other drug that may be deemed necessary in my case, and understand that there is always an element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reaction), cardiac arrest, and thrombophlebitis (e.g. inflammation and swelling in a vein), pain discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs.

I am informed and fully understand that in any type of surgery there are certain unavoidable complications. In dentistry, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws and loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissue, nerve disturbance (e.g. numbness in the mouth and lip tissue), jaw fractures, sinus exposure, swallowing or aspiration of teeth and/or restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal. I realize that there are possible complications and/or risks associated with any type of dental treatment. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation procedure.

I have provided as accurate and complete medical and personal history as possible including any and all allergies to antibiotics, drugs, medications and food. I will follow any and all instructions as explained and directed to me and permit prescribed procedures.

Patient or Guardian Signature_____Date_____

_____Date_____

Witness **Witness Signature**