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CONSENT FOR DENTAL TREATMENT

_____
Date

_____
Patient Name

While serious complications associated with dental procedures are very rare, we would like our patients to be informed about the various procedures involved in dentistry and have their consent before starting treatment. The following risks of complications exist with general dental treatment choices:

Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth (which is usually transient but, on occasion, may be permanent), reactions to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure.

The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reaction, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). *[It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe.] [Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other/additional contraceptive measures be taken during the administration of antibiotics.]*

Consent Certification

I hereby authorize Dr. Riggins to perform local anesthetic injections as necessary to perform the dental treatment for which I am scheduled.

Very inflamed teeth may still have a sensation at the beginning of treatment due to the differences between the chemical makeup of the anesthetic agent and inflammation. If that occurs, additional anesthetic will be administered.

There are some risks in the administration of local anesthetics. Most risks are related the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they might include, but are not limited to, loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs, it is often temporary, and the normal sensation usually returns in several days. However, in very rare cases, the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an

anesthetic may result in an allergic reaction, which is very rare, but may take place. I further understand that individual reaction to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

The success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained. I have had an opportunity to discuss all of the above with the doctor, and have had all of my questions answered.

PLEASE CIRCLE YOUR RESPONSE BELOW:

I have (have not) had local anesthetic injections in the past.

I do (do not) have a problems with local anesthetics with epinephrine (known as novocaine)

I, The undersigned, being the patient (parent or legal guardian of above minor patient or incompetent adult), consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor.

I understand that during the course of dental treatment something unexpected may arise that may necessitate procedures in addition to or different from those currently planned. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made concerning the results of the treatment that I/the patient will receive.

Patient's signature: _____

Date: _____ Time: _____ Print Name: _____

If other than patient, indicate relationship: _____

Consent Certification

I certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, dental treatment. I have offered to answer any questions and have fully answered such questions. I believe the patient/relative/guardian understands what I have explained and has consented to procedures decided upon to be necessary or advisable.

Signature of Dentist: _____

Date: _____ Time: _____ Print Name: _____

Witness Signature: _____ Date: _____