

Disclosure / Consent

The purpose of this disclosure is to inform you, our patient, that the goal of a dentist is to help you attain better health, comfort and appearance by performing some or all of the following services: diagnostic/preventive, restorative, periodontic, prosthetic, cosmetic, endodontic, pediatric, oral surgery and emergency. There are risks inherent when a patient undergoes such procedures. The mechanical and surgical nature of the work and the individuality of each patient's composite physiological, biological and psychological condition is such that any particular outcome cannot be guaranteed by the level of dedication, care, experience and competence of any individual dental practitioner. However, the risks of significantly delaying, postponing and/or elective waiving of recommended treatment are, in general, vastly greater. Infrequently, proposed treatment may cause a worsening of a previous asymptomatic condition or introduce additional undesirable side effects. Dental treatment risks include but are not limited to the following:

- Postoperative discomfort and/or swelling
- Prolonged or delayed bleeding
- Exacerbation of existing or development of new infection
- Development of dried, cracked, crusted corners of lips from stretching
- Peeling of the thin lining of skin inside the mouth from drying
- Sloughing of overlying soft tissue from exposure to chemicals
- Local anesthetic (numbing medicine) risks, especially in the lower jaw, include but are not limited to the following: lack of or inadequate anesthesia, requiring additional medication; hematoma, trismus (prolonged limited opening and soreness of the jaw muscles); temporary or in rare cases permanent numbness to the lips, tongue, teeth, cheek, gums, chin, floor of the mouth and/or loss of or altered taste; and inadvertent biting causing injury to lips, cheeks or tongue
- Chipping or fracturing of treated tooth, and/or adjacent teeth
- Deterioration and death of the dental pulp due to direct or indirect trauma from routine fillings and crowns necessitating additional expensive root canal, post/crown buildup and /or crown protection at additional and full fees
- Air embolism introduced into face, neck, chest
- Cuts, lacerations, bruising, scarring caused by sharp, rotary, or blunt instruments from inadvertent slippage or from slight or sudden movement of the patient's head requiring no treatment, palliative care and observation, or further evaluation and treatment at specialist office at additional fees
- Unexpected, unplanned, compulsory additional dental procedures discovered after treatment started requiring additional time and expense beyond earlier projections
- Risks from dental treatment can vary from very minor to life threatening

- Patient's voluntary withholding of vital health information including past and present medical conditions and medications could adversely affect physical well being during and after dental treatment.
- Prescription and over the counter medications can cause drowsiness, dizziness, upset stomach, allergic reaction, etc. It is pertinent not to drive or operate potentially dangerous machines while under the influence of some medications. Combination with alcohol could greatly increase the dangers of some medications.
- Additional risks specific to particular procedures will be reviewed with you prior to treatment.

I understand and accept the risks of dental treatment outlined above and the risks of nontreatment*(more costly subsequent treatment; additional time required; loss of additional tooth structure and periodontal support; possible increased pain and discomfort; possible loss of teeth and bone compromising future results; loss of chewing efficiency; compromised esthetics and smile; decrease in number of desirable alternative treatments available; and abscesses, swellings and infections which could be life threatening).*

I consent to dental treatment rendered by all persons associated with this office and to all procedures, medications, x-rays, laboratory work deemed necessary by such providers to treat my dental condition.

Name _____ Date ____/____/____

I consent as parent/guardian to all the above for the treatment of the below named child/children/ minor:

child _____ child _____ child _____

child _____

Guardian _____ ***Date*** ____/____/____