General Dental Treatment Consent Form

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 with local anesthesia
- Application of sealants to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations
- The replacement of missing teeth with a dental prosthesis (crown, partials, etc.)
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or developmental abnormalities.
- Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or root canal

Risk of Dental Procedures in General

While unlikely, these are potential risks involved from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections: 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. Tempromandibular joint (TMJ) 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, 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.

Alternative Treatment

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

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

Patient/Guardian Signature: _____

Patient Name (Printed):_____

Date: _____