

CONSENT FORM

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.

(patient)

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required in order to provide proper care. I give my consent to use local anesthetics, relaxants, anti-inflammatory medications, antibiotics, antihistamines, steroids, or pain medication if deemed necessary for the completion of any medical or dental treatment. I fully understand that using such anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I Do/Do Not (circle one) grant permission to take photographs of my mouth or head and neck to be used, without revealing my identity, for the furthering of medical and dental knowledge and education.

I understand that whenever a tooth is extracted, there is the possibility of infection, bone fracture, tooth damage, or temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible, however, that the paresthesia would be permanent.

I understand that root canal treatment is an attempt to retain a tooth that would otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally, a tooth undergoing root canal treatment may undergo acute infection, fracture, or file breakage. It may require re-treatment, surgery or (rarely) extraction. Restoration with a crown should always follow root canal treatment. Sometimes a post is also indicated.

I understand that preparation of teeth for crowns, bridges and fillings may, on occasion, traumatize the pulp (nerve). If the pulp is in a weakened condition, this may necessitate a root canal treatment on the tooth in the future.

Women using birth control medication should be aware, that antibiotics, such as penicillin or erythromycin could possibly counteract the effects of the pill and you could become pregnant.

I realize that a specialist can perform any of the work that the doctor proposes. I will tell the doctor or his staff if I desire that a specialist perform the work.

I also understand that any X-rays taken are the property of the dentist, and that a fee may be charged for any duplication or transfer of said X-rays.

I have not taken any mood or mind altering drugs prior to signing this form.

Signed _____
Patient, Parent or Guardian

Date _____