DENTAL TREATMENT CONSENT FORM

*Patient Name:*_____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned procedure so that you can decide whether to have a procedure or not after knowing the risks, benefits and alternative options.

I understand that good oral hygiene is essential to prevent decay and to assist in the successful treatment of dental conditions.

1. EXAM/X-RAYS/CLEANING/SEALANTS

I give the dentist/dental office permission for my routine examination, x-rays, prophy (cleaning), and sealants.

(Initials _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics, pain medications, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. I know it is important to take any medicines that are prescribed for me as directed to help minimize potential problems. Certain medications may cause drowsiness and I should not drive or operate hazardous equipment when using such drugs. If I have a problem, I should get appropriate medical care from either my doctor or in emergencies by calling 911. (Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that, during treatment, it may be necessary to change or add procedure(s) because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. (Initials_____)

I understand that dentistry is not an exact science and that, therefore; reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date_____

Signature of Parent/Guardian (if patient is a minor) _____ Date_____