KYRENE FAMILY DENTISTRY

Dental Treatment Consent Form

Dear Patient,

Providing the highest quality dental car involves keeping you informed so you can make good decisions about you dental health. Please read the following information carefully. It describes the treatment that is planned for you and any risks and possible complications involved. You have a right to ask questions about anything that you do not understand. We will be please to answer your questions.

In general terms your treatment or procedure(s) will include the following checked (✓) items:

- ☐ Radiographs (x-rays) of the teeth and jaw
- ☐ cleaning of the teeth
- ☐ Application of topical fluoride
- ☐ Applications of plastic “sealants” to the grooves of the teeth
- ☐ Use of local anesthesia to numb the teeth and tissues
- ☐ Treatment of diseased or injured teeth with dental restorations (fillings)
- ☐ Replacement of missing teeth with dental prostheses
- ☐ Removal (extraction) of one or more teeth
- ☐ Treatment of diseased or injured oral tissues (hard and/or soft)
- ☐ Treatment of crooked teeth and/or oral developmental or growth abnormalities
- ☐ Use of sedative drugs to ease apprehensiveness
- ☐ Use of general anesthesia to accomplish the necessary treatment
- ☐ Other_____

Notes:_____

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RISKS INVOLVED IN SURGERIES

_ Soreness, swelling, bruising, and restricted mouth opening during healing, sometimes related to muscle stiffness and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.

- Bleeding, usually controllable, but may be prolonged and require additional car.
- Drug reactions or allergies.

RISKS INVOLVED IN TOOTH EXTRACTIONS

- Dry socket causing discomfort a few days after extraction; requires further care.
- Damage to adjacent teeth or fillings.
- Sharp ridges or bone splinters; may require additional surgery to smooth the area.
- Portions of tooth remaining — sometimes fine root tips break off and may be deliberately left in place to avoid damage to nearby vital structures such as nerves or the sinus.
- Numbness; due to the proximity of the roots to the nerve (especially wisdom teeth) it is possible to injure the nerve during the removal of the tooth. The lip, chin, gums, or tongue could thus feel numb (resembling local anesthetic injection). This could remain for day weeks or very rarely, permanently.

- Sinus involvement; due to the closeness of the roots of upper back teeth to the sinus or from a root tip being displaced into the sinus. Possible sinus infection and/or sinus opening may result, which may require medication and/or later surgery to correct.

RISKS INVOLVED IN ANESTHESIA

LOCAL ANESTHESIA Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage and unexpected allergic reactions which could result in heart attack, stroke, brain damage and/or death.

INTRAVENOUS OR GENERAL ANESTHESIA Certain possible risks exist that, although uncommon, could include nausea, pain, swelling, inflammation, and/or bruising at the injection site. Rare complications include nerve or blood vessel injury (phlebitis) in the arm or hand, allergic or unexpected drug reactions, pneumonia, heart attack, stroke, brain damage, and or/death.

IF YOU ARE TO HAVE INTRAVENOUS OR GENERAL ANESTHESIA PLEASE UNDERSTAND THAT YOU MUST HAVE NO FOOD FOR EIGHT (8) HOURS BEFORE YOUR APPOINMENT. TO DO OTHERWISE MAY BE LIFE-THREATENING.

Notes:_____

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I hereby authorize and direct the dentist(s) assisted by other dentists and/or dental auxiliaries of his/her choice, to perform upon myself or child (or legal ward for whom I am empowered to consent) the checked dental treatment(s) or oral surgery procedure(s). I certify that I have read and understand this consent form, that I have been given an opportunity to ask questions, and that all questions about the procedure(s) have been curative and/or successful to my complete satisfaction. I understand further that I have the right to be provided with answers to questions that may arise during the course of my treatment or that of my child. I further understand that I am free to withdraw my consent to treatment at anytime, and that this consent will remain in effect until such time that I choose to terminate it.

I have been advised that medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination; thus I have been advised not to operate any vehicle or hazardous device for at least 24 hour or until further recovered from the effect of the anesthetic, medications and drugs that may have been given for my car. I agree not to drive myself home, and to have a responsible adult accompany me until I am recovered from my medications.

Signature of Patient or Parent/Guardian: _____ Date: _____

I certify that I explained the above procedure(s) to the patient/parent or legal guardian before requesting this signature.

Dentist Signature: _____ Date: _____