# GENERAL CONSENT AND INFORMATION FORM

It is the belief of this office that you should be informed about the treatment (therapy) we may recommend, and that you should give your consent before starting treatment. The purpose of this form is to tell of the risks that may occur in dental treatment, and other treatment choices.

RISKS OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation 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, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and 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 or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make any/all changes, additions and/ or deletions as the Dentist deems necessary.

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, and understand the risks involved, as well as the possible alternative methods of treatment that have been fully explained to me. I also authorize the operating Dentist and Assistants to perform any other procedure which they may dem necessary or desirable in attempting to improve my condition, or treat unhealthy or unforeseen conditions that may be encountered during treatment.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I am requesting and authorizing. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered me. I also understand that no other Dentist, individual, or corporation, other that the treating Dentist, is responsible for my dental treatment. In order to receive treatment, I contract that if there is any difference or disagreement between my attending Dentist and myself I will first present such difference of disagreement to my attending Dentist to resolve problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the grievance committee of my dental health plan, the Dental society, or California State Consumer Affairs Board of Dental Examiners, and agree to accept their resolution in lieu of pursuing remedies by understand that this agreement is binding on my heirs and all other family members.

Alternatives and possible untoward reactions have been explained to me in detail and clearly, including (but not limited to) bleeding, scarring, numbness, fractured jaw, and allergic reactions which on occasions can be life threatening. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING NOT UNDERSTOOD HAS BEEN EXPLAINED TO ME.

Signature: _____ Date: _____

Patient or Legal Representative