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FAMILY DENTISTRY

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CONSENT FOR INITIAL DENTAL TREATMENT

I request and authorize Dr. _____, and/or associates, hygienists or assistants of his/her choice to perform the following treatments/procedure(s) clinically necessary for diagnosis and for treatment planning for my oral health. I further request and authorize a complete dental examination that may include periodontal probing, dental X-rays, intraoral photographs, soft tissue and oral cancer screening and possible diagnostic study models. In addition to these procedures I authorize and request a dental cleaning or initial periodontal therapy and fluoride treatment. The use of anesthetics may be considered necessary and/or advisable by the doctor responsible for my care.

It has been explained to me, and I have had sufficient opportunity to discuss my initial dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment, compared with alternative approaches and/or no treatment at all.

The usual and most frequent risks or complications occurring from the initial planned treatment and procedures, has also been explained to me. These risks include, but are not limited to, the possibility of pain or discomfort during or following treatment, swelling, infection, bleeding, or if local anesthesia is used, the development of a transient numbness or tingling in the lip, chin, cheek, tongue, teeth or gums that me be temporary or permanent.

I understand that during the course of my dental treatment something unexpected may arise that may necessitate procedures in addition to or different from those initially planned. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made concerning the results of the treatment, I will receive. All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed for me.

I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

I confirm that I have read this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed below.

Patient Signature: _____
Print Patient Name: _____Date: _____Time:_____
If other than patient, indicate relationship: _____
Witness Signature: _____
Print Witness Name: _____Date: _____Time:_____

Consent Certification
I certify that I have explained the nature, purpose, benefits, the usual and most frequently occurring risks and hazards of, and alternatives to the initial treatment prescribed for the patient. I have offered to answer any questions and have fully answered such questions. I believe the patient/parent/guardian understands what I have explained and has consented to the proposed treatment and procedures.

Signature of Dentist: _____
Print Dentist Name: _____Date: _____Time:_____