



## GENERAL CONSENT FOR DENTAL TREATMENT

I understand the purpose of this general consent is to raise my awareness of risks that are common-place in many dental procedures. I understand my dentist reserves the right where appropriate (for example: for root canal therapy, extractions and other oral surgery, treatment of gum disease, placement or restoration of implants, crowns, bridges, dentures, oral and parenteral sedation) to provide me with a more specific informed consent discussion.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with it its own risks. My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity. For routine fillings, dental cleanings, prescription of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of a post operative infection, nerve damage, and iatrogenic injury (an injury that might arise from our treatment or advice). In rare cases, the complications from surgery can be permanent, disabling, or even cause death. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation or breakage of dental instruments which may become lodged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will inform or contact my dentist as soon as possible.

I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment or surgery.

I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications. I promise to use that right to the fullest extent if for any reason I feel I am not fully informed about my procedure, the risks of the procedures, and my alternatives to the procedure.

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SIGNATURE OF PATIENT OR PARENT / GUARDIAN

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PRINTED PATIENT NAME IF OTHER THAN SELF

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DATE