

# CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Parkview Family Dentistry and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids,
  - A. Preventative hygiene treatment, (prophylaxis) and the application of topical fluoride.
  - B. Application of plastic "sealants" to the grooves of the teeth.
  - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
  - D. Replacement of missing teeth with dental prostheses, (bridges, partials, full dentures, or implants).
  - E. Removal (extraction) of one or more teeth.
  - F. Treatment of diseased or injured oral tissues (hard and/or soft).
  - G. Use of sedative drugs to control apprehension and/or disruptive behavior.
  - H. Treatment of malposed (crooked) teeth and/or developmental or growth abnormalities.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, and that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all of these treatments be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgement of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand there are rare risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. PARENTS WITH SMALL CHILDREN- In order to have better communication regarding treatment services and/or treatment needed, a parent or guardian must be present at all appointments for their minor children/dependent(s), unless other arrangements have been made.
7. I also authorize the doctor to use photographs, radiographic and other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patients name \_\_\_\_\_ Date \_\_\_\_\_

Name of Parent or guardian/relationship: \_\_\_\_\_

Signature Patient or Parent or Guardian \_\_\_\_\_