Consent for General Treatment - Adult

I,__________________________________ authorize Dr. Hendrick and his Assistant/Hygienst to perform my treatment plan. I have had the opportunity to discuss my medical history indicating any medications, serious problems, injuries, or allergies. I have had explained to me and have had sufficient opportunity to discuss my dental conditions, planned procedures and treatments. I have had explained to me the expected benefits from this treatment in comparison with alternative approaches or no treatment.

I authorize dental x-rays to be taken. I understand x-rays are advisable and necessary to diagnose and treat my dental conditions. I am also aware, continually refusing x-rays could result in dismissal from the practice.

I understand that antibiotics, analgesics, and other medications can have side effect. Some of these side effects include, but are not limited to: drowsiness, lack of coordination, nausea, redness, swelling of tissues, pain, itching, vomiting, and severe allergic reactions (anaphylactic shock). Local anesthesia can cause a tingling sensation in the lip, chin, tongue, cheek, teeth or gums that could be temporary or permanent. If any of these symptoms occur, I will contact the dentist's office immediately. It is also not advisable to operate any motor vehicle or hazardous device while experiencing any side effect to a medication we have prescribed or administered. Alcohol may also increase these effects. Antibiotics are known to decrease the effectiveness of oral contraceptives.

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 the examination. The most common being, root canal therapy following routine restorative procedures. I give my permission for the Dentist to make these changes as he deems necessary. I also understand, delaying treatment may result in additional discomfort/pain, treatment, and cost. For example: postponing treatment for a tooth needing only a filling, could result in the tooth needing a crown and/or root canal therapy as well as core build up, possible post, or even tooth loss.

I understand that some dental procedures may cause changes in occlusion (biting), jaw or muscle cramps, spasms, referred pain in the ear or neck. I understand that there is always a possibility of delayed healing and/or treatment failure.

The usual and most frequent risks or complications include, but are not limited to: pain, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, temporomandibular (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

All of my questions have been answered to my satisfaction and I give my consent to general treatment.

Signature: ____ Date:____________

Witness: ____ Date:____________