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Dental Informed Consent Statement

Dental treatment for (name)_____

A requirement facing all practitioners of medicine and dentistry is that the patient, or legal representative of the patient, gives the practitioner informed consent. Informed consent indicates your awareness of the negative as well as positive aspects of dental or surgical treatment.

You have our assurance that even though informed consent is a legal requirement of all practitioners of medicine and dentistry, we will endeavor to keep negative implications to a minimum throughout the entire dental or surgical procedure.

The dental or surgical procedure to be preformed has been explained to me and I understand what is to be done. This is my legal consent to the dentistry or oral surgery indicated on the dental record and to any other dental procedure of surgery deemed necessary or advisable in addition to the planned operation.

A healthy, beautiful smile is our goal. However, in dealing with human beings, there are intra-operative and post-operative events that may occur from the dental procedure or surgery. These events **usually** include pain and swelling in the area of treatment; and that **occasionally**, some events include: infection, bleeding, and/or bruising; numbness and tingling on the lips, tongue, cheeks and teeth; stiffness of the neck and facial muscles; changes in the bite (occlusion); pain in the mandibular joints; injury to adjacent teeth or restorations in other teeth; injury to other tissues; referred pain to the ear, neck, and head. **Rarely**, some events include: bone fractures, delayed healing, sinus complications, and oral fistulas (openings).

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which could be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle or hazardous devices, or work while taking such medications and/or drugs until I have fully recovered from the effects of the above. I understand and agree not to operate any vehicle or hazardous devices for at least 24 hours or until fully recovered from the effects of the anesthetic, medication, and drugs that may have been given to me in the office for my care.

I acknowledge the receipt of and understand the post-operative instructions and may be given an appointment date to return. It has been explained to me that there is no warranty or guarantee as to any result and/or cure. I understand I can ask and receive a full explanation of any and all possible risks associated with my care by just asking.

Patient/Parent Signature_____ Date_____

Witnessed _____ Date _____