GENERAL DENTISTRY
INFORMED CONSENT

Name_____

1. **Drugs and Medications**:
   Antibiotics and analgesics and other medications may cause allergic reactions causing shock (severe reaction), redness and swelling of tissues, pain itching, vomiting and/or Anaphylactic shock (severe reaction). Local anesthetic will cause numbness of your Cheek or tongue. Local anesthetic may also cause you to become lightheaded and possibly nauseated.

2. **Changes in Treatment Plan:**
   During treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not evident during examination, the most common being root canal therapy following routine restorative procedures.

3. **Periodontal Loss (Tissue & Bone)**
   Periodontal problems cause gums and bone inflammation or loss which can lead to the loss of teeth. Alternative treatment plans are gum surgery, replacements and/ or extractions. Under taking any dental procedures may have a futures adverse effect on periodontal conditions.

4. **Amalgam/Composite Fillings**
   Care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. A more extensive filling than originally diagnosed may be required due to additional decay. Significant sensitivity is a common after-effect of a newly placed filling. Occasionally after a filling is placed a root canal may be necessary.

Should any dispute arise over dental services provided to me, the dispute will be submitted to Peer Review. The decision of the Peer Review shall be binding on both parties. I have read, understood, and agreed to the above:

Consent for Treatment

I hereby grant authority to the dentist(s) in charge of the patient, whose names appears on this form to administer any treatment, or to administer such anesthetic, analgesics, sedative, nitrous oxide and intravenous sedation, and to perform such operation may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complication of the procedures, anesthetics and/or drugs.

Patient Name:_____

Signature:_____
(Patient, Guardian, Responsible Party)