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# DENTAL TREATMENT INFORMED CONSENT

Patient name (print): _____ Date: _____

Upon reviewing your health history, the doctor will examine you and may require x-rays to make an accurate diagnosis and treatment plan. The doctor will select a treatment plan that best suits your needs. You will be informed of all alternative treatment available to you. Occasionally the plan may have to be altered during treatment, due to unexpected changes. Any vital tooth may require a root canal treatment if it becomes sensitive after being treated.

At this time we would like to inform you of risks that are uncommon but could occur from dental treatment. They are as follows: Soreness, allergic reactions, reaction to injections, pain, infection, continued numbness, laceration and swelling. Prescribed medication and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol and other drugs) thus, is advisable not to operate any vehicle or hazardous device, or to work for twenty-four hours or until recovered from their effects. Antibiotics may interfere with oral contraceptives and caution should be used during antibiotic use.

If there is anything you do not understand, please discuss it with the doctor before signing the statement below.

**AFTER READING AND UNDERSTANDING THE ABOVE RISKS FOR TREATMENT, I HEREBY GIVE CONSENT FOR DENTAL TREATMENT.**

Patient signature: _____ Date: _____
Patient guardian if under 18: _____ Relationship_____