

INFORMATIONAL USE ONLY

INFORMED CONSENT

PATIENT: _____

DATE: _____

1. I, _____, authorize Dr. _____ and/or such assistants as may be selected by him/her to attempt to remedy the following condition(s) or symptom(s) which appear indicated by the diagnostic procedure(s) already performed: _____

2. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the surgery or dental procedure(s).
3. I further acknowledge that the only statements or representations upon which I have relied to consent to this surgery or dental procedure(s) are those contained in this form.
4. The condition(s) listed in paragraph 1 have been explained to me, and I understand the nature of the surgery, dental procedure(s) and anesthetic/sedation procedure(s) to be as follows: _____

5. I have been advised of the availability of, and risks inherent in the following alternate method(s) of treatment: _____

6. I recognize the need for my dentist to exercise his/her professional judgment on my behalf and I therefore specifically authorize my dentist to select alternate methods of treatment based on my condition as disclosed during the procedure(s) authorized by my execution of this form, including conditions which were unknown at the time the surgery or dental procedure(s) were begun.
7. I understand that there are certain inherent risks and consequences that may be associated with any surgical, dental or anesthetic/sedative procedure(s). I understand that not every conceivable hazard can be listed. I realize the following possibilities exist, however infrequent or rare: allergic reactions to medications, anesthetics, etc.; drug interactions and side effects; excessive bleeding (during the procedure and/or after the procedure); postoperative bruising and discomfort; blood clots anywhere in the body; postoperative infection or bone inflammation; possible involvement of the sinus of the upper jaw during removal of upper back teeth, requiring possible surgery for repair at a future date; possible involvement of the nerve with the lower jaw during removal of lower teeth, resulting in usually temporary but sometimes permanent numbness and/or tingling in the lower lip and/or tongue; fracture or dislocation of the jaw; bruising and/or vein inflammation at the site of injections; damage to adjacent teeth, restorations and/or gum tissue. **THESE ARE NOT PROBABLE RESULTS, THEY ARE STATISTICAL POSSIBILITIES.**
8. I am also aware that certain specific risks and consequences may be associated with the surgery, dental procedure(s) and anesthetic/sedative procedure(s) outlined in paragraph 4, including: _____

9. Knowing these risks, I consent to the surgery, dental procedure(s) and anesthetic/sedative procedure(s) outlined in paragraph 4.

Signature

Date