

Informed Consent
General Informed Consent for Treatment

I understand that I may have conditions requiring various dental treatments including:

- Periodontal treatment/Cleanings
- Fillings
- Crowns
- Bridgework
- Implants
- Partial or Complete Dentures
- Endodontics
- Extractions
- TMJ treatment/Occlusal adjustment
- Whitening
- X-rays

All dental and anesthetic procedures have associated risks. These include, but may not be limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-Operative infection
- Post-Operative bleeding that may require further treatment
- Delayed healing of extraction site (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date
- Involvement of nerves during the removal of teeth resulting in temporary or possibly permanent numbness or tingling of lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of the dental procedure necessitating additional treatment
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I understand that treatment alternatives and risks will be discussed, as well as the consequences of doing nothing.

Patient Signature _____

Date _____