Duxbury Dental Associates

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient or guardian, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

PLEASE READ AND INITIAL THE ITEMS BELOW AND SIGN AT THE BOTTOM OF THE FORM

1. TREATMENT TO BE PROVIDED

I understand that during my course of treatment the following care *may* be provided (**please check** ✓):

Examinations ☐ **Preventative Services** ☐ **Restorative Procedures** ☐

Extractions ☐ **Endodontics** ☐ **Other** _____

(Patient/Guardian Initials) _____

2. DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain itching, vomiting and/ or anaphylactic shock (severe allergic reaction).

(Patient/Guardian Initials) _____

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

(Patient/Guardian Initials) _____

_____ _____

(Patient/Guardian Signature) ***(Date)***

PATIENT'S NAME (Please print) _____