Consent to Perform Dentistry

Patient: First Name_____ Last Name_____

I hereby authorize and direct the dentist of Fort Meade Dental and/or dental auxiliaries of the Dentist's choice to perform the following dental treatment, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

1. Preventative hygiene treatment (prophylaxis) and the application of topical fluoride
2. Treatment of disease or injured teeth with root canal treatment and/or restorations
3. Replacement of missing teeth with removable prostheses (dentures, partials, etc.)
4. Extraction (removal) of one or more teeth
5. Treatment of disease or injured oral tissues (hard and/or soft)
6. Orthodontic and/or orthopedic treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

I understand that there are risks involved in treatment(s) and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

The administration of local anesthesia involves certain risks. These include nausea and vomiting, an allergic or unexpected reaction, pain, swelling, inflammation or infection of the injection area, injury to nerve or blood vessels in the area, increased heart rate, and/or cardiovascular or respiratory responses which may lead to heart attack, stroke, or death. Tingling and numbness of the lips, face, cheek, and/or gums may occur. Fortunately, these complications and side effects are not common. Well-monitored anesthesia is generally very safe, comfortable, and well-tolerated. I understand and have been informed of the above risks and complications.

I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. Planned procedures may change because of conditions found while working on the teeth that were not discovered during examination. I therefore authorize and request the performance of any additional procedures that are deemed necessary of desirable to oral health in the professional judgement of the dentist. I authorize the doctors to use photographs, radiographs, digital images, other diagnostic materials, and/or treatment records purpose of teaching, research, and scientific publications. I understand that dentistry is not an exact science of that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Our practice places bonded resin, porcelain, and gold restorations only. Often after the placement of bonded restorations, teeth may exhibit sensitivity and such sensitivity may last only for a short time or may last for much longer. The removal of diseased tooth structure may lead to exposure or trauma to the nerve (pulp tissue). Should the sensitivity increase, endodontic therapy (root canal) may be required. There is a possibility that small fracture lines in tooth structure, usually due to large, old silver fillings that may not be apparent at the time of removal of the silver filling, may manifest as sensitivity after bonding procedure.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatment explained to me. I understand that treatment is subject to modification depending on unforeseen or non-

diagnostic circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I have read and understand the above consent for treatment and I have been given the opportunity to ask questions about my treatment. I have given a complete and truthful medical history, including all medications, drug use, etc.

Patient Signature:_____ **Date:**_____