Table of Contents

1. General Consent for Treatment
2. Permission for Treatment of a Minor
3. Authorization to Release Dental Information
4. General Dental Release
5. Acknowledgement of Receipt of Notice of Privacy Practices
6. Photographs
7. Informed Refusal X-Ray Consent Withheld
8. Release From Liability-Informed Refusal Against Dental Advice
9. Local Anesthesia
10. Tooth Removal
11. Impacted Tooth Removal
12. Surgical Procedure
13. Endodontic (Root Canal) Treatment
14. Intravenous Sedation
15. Inhalation Sedation (Nitrous Oxide-Oxygen)
16. General Periodontal Treatment
17. Informed Refusal - Periodontal Treatment
18. Periodontal Treatment: Non-Surgical or Referral
19. Periodontal Scaling and Root Planing
20. Amalgam “Fillings”
21. Tooth Colored “Fillings”
22. Prosthodontic Treatment – Crowns, Bridges, Veneers, Inlays and Onlays
23. Prosthodontic Treatment - Removable
24. Implants
25. Home Whitening
26. Office Whitening
27. Request for Removal of Amalgam
28. Orthodontic Treatment
29. TMJD Treatment
30. Video Records
31. Bisphosphonates
Informed Consent

General Consent for Treatment

I understand that I have the following conditions requiring treatment in the opinion of my dentist:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

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

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an 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 the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the 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 the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fee(s) involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

Patient Signature __________________________________________ Date ________________

Witness _________________________________________________ Date ________________