Galstan &Ward Family Dentistry

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INFORMED CONSENT FOR DENTAL TREATMENT

Name: _____

Procedure: _____

The dental procedure to be performed on me today has been explained to me and I understand what is to be done. This is my written request to have the dental treatment indicated performed, and to have any other treatment deemed necessary as a result of findings during the planned procedure. I agree to the use of local anesthesia. I have fully informed the dentist of my medical history and any potential complications that I am aware of. I have completed my medical history accurately and truthfully, and I have informed the dentist of any changes that may have occurred since I originally completed my medical history form with this office. I understand that
the expected results of the proposed dental treatment cannot be guaranteed, nor is there any guarantee that the proposed dental treatment will be curative and/or successful to my complete satisfaction. I am aware that individual patient differences result in the risks of failure, relapse, need for selective re-treatment, or worsening of the present condition despite the care provided. I understand that failing to follow instructions concerning my care will increase the chance of a less than optimal result. Most procedures result in favorable results and serious complications, while possible are not usually expected. Such complications, however, are possible with all procedures, and include, but are not limited to (and are not listed in order of potential for occurrence):

1. **Postoperative swelling, discomfort, bruising, delayed healing and infection, which may necessitate several days of home recuperation, and additional treatment and return visits.**
2. **Injury to adjacent teeth, structures, fillings, restorations, prosthesis, hard and soft tissues.**
3. **Stretching, cracking, and/or bruising of the face, jaw, neck, and/or corners of the mouth.**
4. **Heavy bleeding which may be prolonged.**
5. **Restricted mouth opening for several days or weeks.**
6. **Transitional or permanent temperomandibular (TMJ) joint pain and symptoms following the procedure.**
7. **Breakage of the root tips of teeth in the jaw, which may necessitate referral to an oral surgeon for their removal, or deciding to leave these root tips in place in the jaw when their removal would require extensive surgery.**
8. **Displacement of pieces of teeth or bone into soft tissue or the sinus, which may necessitate referral to an oral surgeon for the removal, or which may be left in place, when their removal would require extensive surgery.**
9. **Injury to nerves which may result in numbness, tingling or pain of the lip, chin, gums, cheek, teeth and/or tongue, which may persist for days, weeks, months or even permanently.**
10. **The appearance of sharp ridges or bone splinters after a procedure, which may necessitate additional procedures, or which may necessitate referral to an oral surgeon for an additional procedure.**
11. **Opening into the sinus above upper teeth, after their extraction, which may necessitate referral to an oral surgeon or physician for an additional procedure.**
12. **Post-procedure irritation or sensitivity.**
13. **Breakage or fracture of the jaw.**
14. **Referral to a specialist, who may perform additional procedures at additional fees, for which the patient is responsible for such payment.**
15. **Severe and harmful reactions to local anesthetics, procedures and prescribed medications.**
16. **Female patients who are prescribed antibiotics have been counseled to use an additional method of birth control other than oral contraceptives.**

Anesthetics and prescriptions drugs may cause drowsiness, thus I have been advised not to operate any vehicle or hazardous devices or perform dangerous work while taking such medications and/or drugs until fully recovered from their effects. Results of this procedure are not guaranteed in any way. I certify that I read, speak and write English, or that I have an interpreter who does, and that I have read and fully understand this informed consent for dental treatment, and that I acknowledge the potential risks of this dental treatment. I have asked the doctor any questions that I have concerning this dental procedure and consent form and they have been answered to my satisfaction.

_____ _____

SIGNATURE OF PATIENT (or PARENT/GUARDIAN) ***DATE***

Relationship to Patient: _____ Self ___ Other (explain): _____

_____ _____

SIGNATURE OF WITNESS ***DATE***