

EXCEPTIONAL NEEDS DENTAL SERVICES
CONSENT FOR DENTAL TREATMENT
AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

This disclosure is meant to help you make a decision regarding your dental care. State law requires us to obtain your consent prior to dental treatment. You have the right to be informed about your diagnoses, recommended dental treatment, treatment alternatives, and risks. Please ask us about anything you do not understand. We are ready to answer your questions or explain anything.

Possible Risks or Complications to All Dental Surgeries or Extractions

- Swelling, Bruising, Pain
- Trismus (jaw pain or difficulty opening mouth)
- TMJ Dysfunction (the jaw joint may be painful or not function properly)
- Infection
- Bleeding
- Failure of wound to heal
- Dry socket
- Nerve damage
- Loss of teeth or bone
- Instrument breakage
- Injury to adjacent structures, teeth, fillings, hard or soft tissue
- Incomplete removal of tooth, breakage of root(s) and/or retained root fragments
- Swallowing and/or aspiration of objects
- Perforation of root during root canal procedure
- Bacterial endocarditis (infection of heart)
- Failure of treatment to accomplish its purpose
- Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complications(s)
- Death (in rare instances)

Possible Risks of Anesthesia

There are risks associated with the administration of any local or general anesthetic, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental treatment. Possible risks include pain, swelling, bruising, nerve damage, idiosyncratic or allergic reactions, which may result in heart attack, stroke, brain damage, and/or death.

CONSENT

I, _____ (patient name), acknowledge that I have read the above information, or that it has been read to me, and I understand the information contained on this consent form.

I hereby consent to and authorize the dentist and/or associates to perform the following diagnostic, surgical, and/or dental treatment and administer the necessary anesthesia:

Full Mouth Dental Rehabilitation under general anesthesia to include:

Radiographs, Cleaning, Restorations (fillings) and Extractions

I consent for the dentist and/or associates to use their best judgment in treating unexpected findings and to perform such other procedures that are advisable in their professional judgment.

Alternatives to the recommended treatment, including no treatment, have been explained to me.

I had adequate opportunity to ask any questions and all my questions have been answered to my satisfaction.

DATED this _____ day of _____, 200____.

Signed:

Signature of Patient or Guardian

Print Patient's Name

Witness

Date

Dentist

If I, the **Legal Guardian or Qualified Consenter**, cannot be present at the time of surgery, I **will be available by phone between 6:00am to 5:00pm on the day of surgery**. This contact number is important to obtain further consent if deemed necessary for any treatment that could not be previously discussed. Failure to provide this contact number could cancel the case.

Phone: () _____