General Consent For Treatment

We are required to obtain your consent for contemplated or proposed dental treatment or oral surgery. Please read this form carefully and we encourage you to ask us about anything that you do not understand. We will be glad to explain it to you.

1. I, hereby authorize and direct Monroe Dental Clinic, assisted by licensed dentists and / or dental auxiliaries of their choice to perform upon me, or my child (name) _____ the following dental treatment or oral surgery procedures including or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. In general terms, the dental procedures may include one or a number of the following:
   * Cleaning of the teeth and application of topical fluoride.
   * Application of sealants to the grooves of the teeth.
   * Treatment of diseased or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
   * Stainless Steel Crowns for children. These are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities.
   * The replacement of missing teeth with a dental prosthesis (crown, partials, etc).
   * Extraction (removal) of one or more teeth that cannot be saved.
   * Treatment of diseased or injured oral tissues (hard and / or soft).
   * Treatment of malposed (crooked) teeth and / or development abnormalities.
   * The use of sedative medications and / or nitrous oxide to control apprehension and / or Disruptive behavior.

The treatment has been explained to me. I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed Alterative methods of treatment, if any have explained to me, as have the advantages and disadvantages of each. I am advised that good results are expected: however, the possibility and nature of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I further understand and authorize the doctor to perform any necessary treatment that in his/ her judgment will be in the best interest of my or my child's health, once treatment has been initiated.

3. Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedures, medication and / or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, and scarring. I understand and accept that complications may require medical assistance, hospitalization and in very rare cases death.

I hereby state that I have read and fully understand this consent. I have been given an opportunity to ask questions regarding this consent. I have been given the opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time that I choose to terminate. Such termination of consent must be in writing.

Patient Name: _____

Signature of Patient/ Guardian: _____

Witness: _____ Date: _____