DENTAL TREATMENT AUTHORIZATION AND CONSENT

THIS DENTAL TREATMENT AUTHORIZATION AND CONSENT (this "Consent") is dated as of _____ ___, and is executed by _____ ("Patient").

By executing this Consent below, the Patient acknowledges his/her willingness to accept and assume the risks and any complications of treatment.

1. ACCURACY OF INFORMATION. In order to receive appropriate care, treatment, and follow-up, it is very important for the Patient to provide the Dentist with accurate information before, during, and after the dental treatment.

2. CONSIDERATION OF RISKS AND ALTERNATIVES. Before authorizing and consenting to the dental treatment, Patient should carefully consider the potential benefits and risks of the recommended procedure(s). Patient should also consider alternative treatments and the option of no treatment. Patient should not authorize and consent to any treatment until the advantages, potential benefits, risks, potential complications, side effects, and recovery times are discussed with the Dentist or other authorized physician.

3. FOLLOW ADVICE. It is very important that the Patient follow the Dentist's advice and recommendations regarding medication, pre and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If the Patient fails to follow the advice of the Dentist, the Patient may exacerbate the chances of a poor outcome. Failure to take medications prescribed in the manner prescribed may cause risks of continued or aggravated infection, pain, and potential resistance to the effective treatment of the Patient's condition. Patient understands that the success of treatment depends in part on the Patient's efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

4. ASK QUESTIONS; NO GUARANTEE. Before treatment, the Patient should ask questions and receive answers from the Dentist to the Patient's satisfaction. Patient understands that there is no guarantee as to any particular treatment outcome.

5. ORAL CONTRACEPTIVES. If the Patient is a woman on oral birth control medication, the Patient is advised that any antibiotics taken in connection with the dental treatment might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if the Dentist prescribes, or if you are taking antibiotics.

6. DISCLOSURE OF MEDICAL CONDITIONS. Patient's medical conditions must be discussed with the Dentist prior to any procedure.

7. EXAMINATION AND X-RAYS. The Patient understands that the initial visit may require X-rays in order to complete the examination, diagnosis, and treatment plan.

8. DRUGS, MEDICATION, AND SEDATION. The Patient has been informed and understands that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. The Patient understands and agrees not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that are provided as part of the dental treatment.

9. CHANGES IN TREATMENT PLAN. The Patient understands that during treatment, it may be necessary to change or add procedures due to issues discovered while the Dentist is working on the Patient's teeth which were not discovered during the initial examination. Most commonly, this may consist of root canal therapy following routine restorative procedures. Patient hereby gives permission to the Dentist to make any or all changes and additions as necessary.

10. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ). The Patient understands that the TMJ symptoms of popping, clicking, locking, and pain can intensify or develop subsequent to certain routine dental treatment. The Patient understands that should the need for TMJ treatment arise, the Patient will be referred to a specialist for treatment at Patient's sole cost and expense.

11. FILLINGS AND RESTORATIONS. The Patient understands that care must be exercised in chewing on any new filling during the first 24 hours post-treatment in order to avoid breakage and that tooth sensitivity is a common after-effect of a newly placed filling.

12. REMOVAL OF TEETH (EXTRACTION). An alternative to removal has been explained to the Patient (root canal therapy, crowns, periodontal surgery, etc.), and the Patient authorizes the Dentist to remove the specified teeth discussed with the Dentist and any others necessary. The Patient understands that removing teeth does not always remove all infections and that further dental treatment may be needed. The Patient understands the risks involved in having teeth removed, some of which include pain, swelling, the spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue, which can last for a period of time, and a fractured jaw. The Patient understands that he/she may need further treatment by a specialist (including potential hospitalization) in the event complications arise during or following treatment. Any such treatment shall be at the Patient's sole cost and expense.

13. CROWNS, BRIDGES, VENEERS, AND BONDING. Patient understands that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. The Patient further understands that if he/she is wearing temporary crowns, they may come off easily, and the Patient must be careful to ensure that they are kept on until the permanent crowns are delivered.

14. PERIODONTAL TREATMENT. For Patients with a serious condition causing gum inflammation and/or bone loss, the Patient understands that this condition can lead to the loss of the Patient's teeth. Alternative treatment plans have been explained to the Patient, including nonsurgical cleaning, gum surgery, and/or extractions.

This form is intended to provide the Patient with an overview of information, potential risks, and potential complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the information herein and the potential benefits, risks, and complications of recommended treatment with the Dentist, and assure yourself that the Dentist has addressed your questions to your satisfaction.

IN WITNESS WHEREOF, the undersigned executes this Dental Treatment Authorization as of the date indicated below.

Printed Name: _____

Signature: _____

Date: _____

WITNESS:

Printed Name: _____

Signature: _____

Date: _____