

## **INFORMED CONSENT FOR GENERAL DENTISTRY AND ANESTHESIA**

State law requires us to obtain your consent to your contemplated treatment, surgery or medical procedure. What you are being asked to sign is a confirmation that we have discussed the nature and purpose of your contemplated treatment, surgery or medical procedure and the risks associated with it and that we have answered all of your questions in a satisfactory manner. Please read the form carefully. Ask about anything you do not understand. We will be pleased to explain.

I, the undersigned, hereby authorize and request **Dr. L. King Scott and/or his associates** to perform the following treatment/procedure/surgery on me:

1. General Dentistry – filling(s) (restorations), crown(s), bridge(s), root canal therapy and/or other.
2. Periodontal Treatment
3. Emergency Treatment – \_\_\_\_\_
4. Single Tooth Extraction
5. Multiple Tooth Extraction
6. Extraction of Third Molars
7. Incise and Drain
8. Apicoectomy
9. Treatment for Dry Socket (osteomyelitis)
10. Other – \_\_\_\_\_

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. Dr. Scott has advised me that if this condition persists without treatment or surgery, my present condition will probably worsen in time, and the risks to my health may include, but are not limited to the following:

Swelling; pain; infection; cysts formation; periodontal (gum) diseases; dental caries; malocclusion; pathologic fracture of jaw; premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

The reason for and the nature of these procedures have been explained to me. Alternative methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages of each. I have been advised that, although good results are expected, the possibility and nature of all possible complications cannot be accurately anticipated and that, therefore, there can be no guarantee as to the results of the procedure/surgery.

I consent to the performance of the above procedure(s), as well as to the performance of such additional alternative procedure(s), as in the judgment of the above doctor, may be necessary to restore and/or preserve my overall dental health, as well as to treat the particular dental disorder(s) described to me.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the procedure or as to cure.

Dr. Scott has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

1. Drug Reaction – A reaction is possible for any medication given and could include nausea, rash, anaphylactic shock and/or death.
2. Soreness at injection site may develop as well as some discoloration of the injection site.
3. Stretching of the corners of the mouth with resultant cracking and bruising.
4. Injury to adjacent teeth and fillings.
5. Swallowing and/or breakage of instruments.
6. Swallowing and/or breakage of materials, prosthesis, appliance, crown(s), bridge(s), temporary crown(s), and temporary bridge(s).
7. Restricted mouth opening for several days or weeks.
8. Post-operative discomfort and swelling that may necessitate several days of home recuperation.
9. Heavy bleeding that may be prolonged.
10. Fracture of a root.

11. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
12. Breakage of the jaw.
13. Paresthesia to jaw, face, neck.
14. Injury to the nerve underlining the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, or in other instances, permanently.
15. Opening of the sinuses (a normal cavity situated above the upper teeth) requiring additional surgery.
16. If intravenous medication is used, soreness at injection site along the vein may develop as well as some discoloration of the injection site.
17. Dry socket.
18. Post-operative infection, requiring additional treatment.
19. Initial bleeding, soreness, swelling, and bruising.
20. \_\_\_\_\_

I have had an opportunity to discuss with Dr. Scott my past medical and health history including any serious problems and/or injuries.

I also authorize and direct Dr. Scott with associates or assistants to provide such additional services as they may deem reasonable and necessary including, but not limited to, the administration of any anesthetic agent, or services of the X-ray department or laboratories, and I hereby consent there to.

Some risks known to be associated with this procedure, including anesthesia are: Brain damage; quadriplegia (paralysis of all arms and legs); paraplegia (paralysis of both legs); loss of organ; loss of arm or leg; loss of function of organ; loss of function of arm or leg; disfiguring scars; death.

I consent to administration of anesthesia, including local, intravenous, and/or general anesthesia necessary for Dr. Scott (and/or his designated assistants) to accomplish the proposed procedure.

I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires an anesthetic.

If any unforeseen condition should arise in the course of the operation calling for Dr. Scott's judgment or for procedures in addition to or different from those now contemplated, I request and authorize Dr. Scott to do whatever he may deem advisable.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite care provided. However, it is Dr. Scott's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I agree to cooperate completely with the recommendations of Dr. Scott while I am under his care, realizing that any lack of same could result in a less than optimum result.

I consent to the taking and use of photographs, material, tissue, and records pertinent to my case in the advancement of dental teaching, research, demonstration, and the writing of articles for scientific publication.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE. ALL QUESTIONS ABOUT THE PROCEDURE HAVE BEEN ANSWERED IN A SATISFACTORY MANNER, AND ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I READ AND WRITE ENGLISH.

**This consent form is valid until revoked by me in writing.**

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

I certify that all blanks in this form were filled in prior to signature and I explained them to the patient or his representative before requesting the patient or his representative to sign it.

Doctor's Signature \_\_\_\_\_

In the event of my failure to pay the balance in full within 30 days of the date services rendered, I agree to pay finance charges of 1½% monthly (APR: 18%) on the unpaid balance.

Signature

Date