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CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthesia agent, analgesic agent(s) to produce conscious sedation and/or premedication prior to dental care being rendered. Some of these risks/complications are, but are not limited to the following:

Infection	Failure of treatment to accomplish main purpose
Bleeding	Trismus (jaw pain or difficulty opening mouth)
Failure of wound to heal	Breakage of root(s) and retained root fragments and/or aspiration of objects
Loss of bone	Opening between mouth and sinus or mouth and nose
Instrument breakage	Injuries to adjacent teeth and/or hard soft tissue
Bacterial endocarditis	Swallowing
Loss of teeth	Dry Socket
Incomplete removal of tooth	Injury to adjacent structures
Allergic reaction to drugs	Tooth or fragment in maxillary sinus
Death (in rare instances)	Paresthesia or numbness of tongue and/or mouth/face
Fracture of mandible or maxilla	Slough (unanticipated loss of hard and/or soft tissue)

Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s).

ACKNOWLEDGMENT

I acknowledge that I have read this consent form, or that is has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienist, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid unless revoked by me in writing.

Signature of Parent/Guardian ______________________________________ Date ________________