

GENERAL CONSENT

Patient Name: _____ Date: _____

I here by authorize my dentist Dr. Allan Szeto and whomever he may designate and his associate, assistants and/or hygienists, to perform upon me/my child those dental procedures which we have discussed, and I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures requiring, in their judgment, procedures in addition to or different from those now contemplated, and after appropriate discussion, I further request and authorize whatever he/she deems advisable. I consent to the treatment plan I accepted after having been advised on any alternative treatment available.

I have been informed and fully understand that there are certain risks in any treatment. These risks include but are not limited to:

- ◆ Post treatment pressure, temperature sensitivity, pulpal inflammation, pain or throbbing.
- ◆ Fracturing of new restorations due to early biting pressures.
- ◆ Tenderness of abutment teeth after crown preparation and cementation.
- ◆ Tenderness of tissue under revolvable appliances.
- ◆ Post surgical pain, throbbing, swelling, bleeding, re-infection and root fracture during surgery.
- ◆ Fracturing of files or coronal portion of a tooth during and following endodontic procedures.
- ◆ Sensitivity of teeth and/or tissues after routine prophylaxis and scaling and root planing.
- ◆ TMD – jaw pain or tenderness of jaw joint.
- ◆ Nerve disturbances (e.g., numbness in mouth and lip tissue). These complications may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in me/my child's case, including, but not limited to:

- ◆ Local anesthetics, antibiotics and analgesics.

I understand that there is an element of risk inherent in the administration of any drug or anesthetic. This risk includes, but is not limited to the following complications:

- ◆ Adverse drug reaction (e.g., allergic reaction), cardiac arrest, thrombophlebitis, (e.g., irritation and swelling of a vein), aspiration, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of medications, drugs or anesthetics.

I have been given the opportunity to discuss these complications and a more complete explanation is available to me upon request from the Doctor.

I am aware that, even though there are these complications and risks, me/my child's treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Date

Patient / Parent / Guardian Signature

Witness