CONSENT FOR DENTAL PROCEDURE(S)

I acknowledge that the dental procedure(s) I am about to undergo carries inherent risks and the potential for varied outcomes, including the possibility of failure. In order to make an informed decision regarding my treatment, I require comprehensive information about the proposed procedure, its associated risks, available alternatives, and the consequences of opting out. I confirm that the dentist has adequately provided this information to my satisfaction.

The dentist has discussed the nature of my dental condition with me: Dental Health Issues.

By affixing my signature to this informed consent form, I acknowledge my understanding and acceptance of the risks, potential unsuccessful results, and/or failure associated with, but not limited to, the following:

Postoperative discomfort—Such as dry socket, which may necessitate additional care, particularly common in lower extractions, notably wisdom teeth, and among smokers.
Tissue alterations—Possibility of gum recession or temporary changes in tissue height, with rare instances of persistent effects.
Residual fragments—The formation of sharp ridges or root tips, which may require subsequent surgical intervention for removal.
Sinus complications—Potential displacement of root fragments into the sinus or development of openings between the sinus and mouth, possibly requiring further intervention.
Surgical complications—Including but not limited to infection, loss of fillings, damage to adjacent teeth or soft tissues, jaw fractures, sinus exposure, or accidental ingestion or inhalation of surgical instruments or materials.

Alternative interventions—Discovery of unforeseen conditions during the procedure that may necessitate modifications to the original plan or alternative treatments, as deemed appropriate by the dentist.

Sensory changes—Acknowledgment of the possibility of temporary or permanent numbness, as well as rare instances of adverse reactions or injury associated with local anesthesia administration.

Patient responsibilities—Agreement to promptly report any unexpected issues and adhere diligently to postoperative instructions, including attending scheduled appointments.

I confirm that I have had the opportunity to seek clarification on any aspects of the proposed treatment and have been provided with satisfactory answers. I understand that I have the option to seek specialized endodontic therapy if desired. I willingly assume all potential risks, including the risk of significant harm, associated with the treatment, in pursuit of desired outcomes, which may not be guaranteed.

I have been informed of the associated fees and insurance coverage, which I find acceptable.

By signing below, I authorize Dr. _____ to perform necessary and advisable treatment for my dental condition, including the administration of anesthesia and medications.

Patient's Name (Printed): _____

Patient's Signature or Legal Guardian: _____

Date: _____