



General Consent for Treatment

Please review the following information in regards towards treatment. It is important to understand that all dental and anesthetic procedures have associated risks.

These may be but are not limited to:

1. Drug reactions and side effects.
2. Damage to adjacent teeth or fillings.
3. Post-operative infection.
4. Post-operative bleeding which may require additional treatment.
5. Bruising, swelling, sensitivity or pain.
6. Failure of the dental procedure necessitating additional treatment.
7. Complications during treatment necessitating referral to a specialist.

I understand I have the right to ask questions about my treatment, including alternatives and risks, as well as, the consequence of doing nothing.

Patient or Parent/Guardian Signature: _____ Date: _____

Staff Member Signature: _____ Date: _____