Consent To Perform Dentistry

I hereby authorize and direct the dentist at Valley River Family Dental PC and/or the dental auxiliaries of his choice, to use any necessary or advisable local anesthetic, radiographs (x-rays), and/or diagnostic aids as needed and/or agreed upon in order to perform the following dental treatment or oral procedures as needed and/or agreed upon:

1. Preventive hygiene treatment and the application of topical fluoride
2. Application of "sealants" to the grooves of teeth.
3. Use of conscious sedation and/or general anesthesia to accomplish the necessary treatment.
4. Use of sedative drugs to control apprehension and/or disruptive behavior.
5. Treatment of diseased or injured teeth by use of dental restorations (fillings and/or crowns).
6. Treatment of diseased or injured oral tissues (hard and/or soft)
7. Extraction (removal) of one or more teeth.
8. Root canal therapy
9. Periodontal surgery
10. Temporal mandibular dysfunction
11. Removable partial/complete dentures

I understand there are possible risks and/or complications associated with the above said treatment, the administration of local anesthesia, sedation and/or general anesthesia, and/or drugs. Some risks and/or complications include but are not limited to: swelling; bleeding; pain; nausea; vomiting; bruising; itching; tingling, numbness and/or pain of the lips, gums, teeth, face, cheek, and/or tongue; allergic reactions; hematoma (swelling or bleeding at or near the injection site); fainting; lip and cheek biting resulting in ulceration and infection of tissue; respiratory (breathing) and/or cardiac (heart) arrest which might cause a lack of oxygen to the brain resulting in brain damage or death; etc.

I understand sometimes it is not possible for dental restorations or artificial teeth to match the exact color of natural teeth. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. I realize that full or partial dentures are artificial and constructed of plastic, metal and/or porcelain. I know that my eating style, ability to pronounce sounds, and generalized mouth movements may need to be altered in order to accommodate the dentures stability in the mouth. Soreness of tissues, looseness and possible breakage of the prosthesis may result with dentures. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be at the "teeth in wax" try-in visit. I understand most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee.

I understand there is no guarantee that root canal treatment will save a tooth. Complications may occur from the treatment and sometimes metal objects are cemented in the tooth or extend through the root. I understand after a root canal is performed, there is risk of re-treatment, surgery, and the possible loss of tooth due to unforeseen circumstances such as fractured roots, uncontrolled bacteria, etc.

I recognize during the course of treatment, unforeseen circumstances may necessitate different and/or additional procedures other than the original plan discussed. I authorize and request the performance of the needed procedures to attain the desirable results of oral health and well-being in the professional judgment of the doctor.

I know the success of the dental treatment provided will require that I follow the post-treatment instructions given by the doctor or other dental auxiliaries and I keep all post-treatment appointments. Failure to follow instructions and keep appointments may result in a poor prognosis (outcome) of the treated tooth or teeth and may require different and/or additional procedures.

I agree that the clinic can use photographs, radiographs, study models, diagnostic materials, and treatment records for the purpose of teaching, research or to assist patients in choosing appropriate treatment options.

I understand that there are risks and/or complications involved with any dental treatment. I may ask questions at any time regarding treatment and the risks/complications associated with treatment. All questions concerning this consent have been answered to my satisfaction.

I have read (or have had the above read for me) and fully understand the above consent.

_____ _____

Signature of patient Witness

_____ _____

Signature of parent/guardian if patient is a minor Date