



902 Dupont Road ♦ Louisville, KY 40207

## CONSENT TO PERFORM DENTISTRY

I hereby authorize and direct the dentist(s) of the Davis Dental Center of Louisville to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, or diagnostic aids:

- Consult with examination for future treatment.
- Preventive hygiene treatment (prophylaxis), and the application of topical fluoride.
- Application of plastic "sealants" to the grooves of the teeth.
- Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
- Replacement of missing teeth with dental prostheses (i.e. bridges, partials, and full dentures).
- Removal (extraction) of one or more teeth
- Treatment of diseased or injured oral tissue (hard and/or soft).
- Use of sedative drugs to control apprehension and/or disruptive behavior
- Treatment of malposed (crooked) teeth and/or oral development of growth abnormalities.
- Use of general anesthesia to accomplish the necessary treatment.

I understand that there are risks involved in this treatment, and hereby acknowledge that these risks will be explained to me. I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient to follow post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performances of any additional procedures that are deemed necessary for desirable oral health and well being, in the professional judgment of the dentist.

There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping or breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose, which disappears shortly after procedure. I understand and have been informed of the above risks and complications.

I also authorize the doctor(s) to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research, and scientific publications.

I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided an answer to the questions which may arise during and after the course of my treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name: \_\_\_\_\_

Name of Parent or Guardian (minors only): \_\_\_\_\_

Signature of Patient or Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_