CONSENT FOR DENTAL TREATMENT

FAMILYFIRST HEALTH

PATIENT NAME:_____ **CHART:**_____

DATE:_____

TREATMENT NEEDED:
I understand that I will have the following treatment done:
☐ Exam ☐ X-rays ☐ Cleaning ☐ Other _____
(*Initials*_____)

MEDICATIONS:
Medications can cause allergic reactions. Allergic reactions can include: redness and swelling, itching, vomiting, pain, and permanent numbness. They might even cause life-threatening problems. (*Initials*_____)

LOCAL ANESTHESIA:
Local pain killers are usually very safe. Sometimes they can cause bruising, swelling, soreness, pain, permanent numbness, and an increase in heart rate. (*Initials*_____)

CHANGES IN TREATMENT:
My treatment plan might have to be changed during treatment. This can happen if other problems are found while working on my teeth. For example, a filling was planned. After the dentist removes all the decay, it is determined that root canal therapy is needed. (*Initials*_____)

FILLINGS:
If I get a filling, I must be careful about what I eat and how I chew for 24 hours so I don't break my new filling. It is common to feel sensitivity after getting a filling. (*Initials*_____)

Dentistry is not an exact science. My dentist can't guarantee exact results. I understand that the dentist has made no promises about my dental care.

I give the dentists and assistants of Family First Health permission to do the dental treatment as explained to me.

Patient Signature:_____ Date:_____

Dentist Signature:_____ Date:_____