

Dental Treatment Consent Form

Consent for X-rays

In providing the best possible dental care for you, we may need to expose and evaluate x-rays to help us with proper diagnosis. With use of a lead shield, dental x-rays provide minimal radiation exposure and provide valuable information necessary for your health.

_____ Yes, I agree and accept x-rays for proper diagnosis

_____ No. I voluntarily refuse to get x-rays. I understand that this is against medical advice and will significantly hinder the doctor from properly diagnosing conditions I may have. I will not hold the doctor liable for any failure to diagnose or improper treatment choices that directly result due to lack of x-ray information.

Local Anesthesia Consent

I understand that local anesthesia is often used during the dental treatment. This consent form is designed to make you aware of the following risks involved with local anesthesia. These include but are not limited to:

- It may affect your body such as dizziness, nausea, vomiting, increase or decrease in heart rate, or allergic reactions, which may require medical management or hospitalization.
- Restriction in mouth opening called trismus, at the site of injection requiring physical therapy.
- Prolonged numbness sometimes causing injury from biting or chewing on areas such as lip, cheek or tongue.
- Injury to nerves can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gums, or tongue. This may persist for weeks, months, years, or very rarely permanent.

Treatment Consent

I authorize the dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a proper and thorough diagnosis of my dental needs. Upon such diagnosis I authorize the dentist to perform all recommended treatments, procedures, and medication administrations as prescribed by the dentist and agreed upon by me, or my legal guardian. I understand that during treatment it may be necessary to change or add procedures because of conditions found while treating the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary.

For crown and bridge work, I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge will be before cementation.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my insurance policy to the dentist, and authorize Dr. Gerlach to submit claim forms and receive payments directly with the notation "signature on file". I authorize release of my treatment records, x-rays, and others deemed pertinent to my insurance as requested. I agree to be responsible for payment of all services rendered on my behalf or to my dependants. I agree that I am responsible for any unpaid claims.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient Name (printed) _____ Date _____

Patient Signature _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____