Informed Consent

General Consent for Treatment

All dental and anesthetic procedures have associated risks. These may be, but no limited to:

* Drug reaction and side effects
* Damage to adjacent teeth and/or fillings
* Post-operative infection
* Post-operative bleeding that might require additional treatment
* In the case of extractions, delayed healing of the site may occur, necessitating additional care
* Sinus involvement during removal of upper molars which may require additional treatment and/or surgical repair later
* Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
* Bruising, Swelling, sensitivity, or pain
* Failure of dental procedure necessitating additional treatment
* Breakage of dental instruments inside the tooth canals necessitating additional treatment
* Complication during treatment necessitating referral to a specialist
* **COVID-19 virus/any other viruses**- I confirm that I have not knowingly been in close contact with someone who has tested positive in the last 7-14 days.
* I understand that due to the frequency of visits of other care dental patients, characteristics of the virus, and the characteristics of the dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though standard precautions are being observed.

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. I also understand that my cooperation during treatment (home oral hygiene upkeep, medication regimens, keeping appointment, etc.) is required to achieve the best results. Any fee(s) involved have also been explained. All my questions have been answered, and I have not been offered any guarantees.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_