PatientXpress
Practice Profitability Solutions

Johnson, Daniel (05/28/1961)

General Consent For Treatment

We are required to obtain your consent for contemplated or proposed dental treatment or oral surgery. Please read this form carefully, and we encourage you to ask us about anything that you do not understand. We will be glad to explain to you.

I, hereby authorize and direct Smiles Dentistry, or any of it's subsidiaries, assisted by licensed dentists and / or dental auxiliaries of their choice to perform upon me, or my child the following dental treatment or oral surgery procedures including the necessary or advisable local anesthesia, radiographs (x-ray) or diagnostic aids.

In general terms, the dental procedures may include one or a number of the following:

- Cleaning of the teeth and application of topical fluoride.
- Application of sealants to the grooves of the teeth.
- Treatment of diseased or injured teeth with dental restoration. This restoration may either be amalgam (silver) or composite (teeth).
- Stainless steel crowns for children. These are necessary in cases where there are large cavities.
- The replacement of missing teeth with a dental prosthesis (crowns, partials, etc)
- Extraction (removal) of one or more teeth that cannot be saved.
- Treatment of diseased or injured or tissues (hard and / or soft)
- Treatment of malposed (crooked) teeth and / or development abnormalities.
- The use of sedative medications and / or nitrous to control apprehension and / or disruptive behavior.

The treatment has been explained to me. I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed with alternative methods of treatment, if any have been explained to me, as have the advantaged and disadvantages of each. I am advised that good results are expected; however, the possibility and nature of complication cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding treatment. I further understand and authorize the doctor to perform any necessary treatment that in his / her judgement will be in the best interest of my or my child's health, once treatment has been initiated.

DISCLAIMER: *Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedures, medication and / or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, and scarring. I understand and accept the complications may require medical assistance, hospitalization and in very rare cases death.*

I hereby state that I have read and fully understand this consent. I have been given an opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent must be in writing.

Daniel Johnson

Signature of Patient/Guardian:

Witness: Nancy Johnson