INFORMED CONSENT

GENERAL CONSENT FOR DENTAL TREATMENT

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that may require additional treatment
- Delayed healing of an extraction site, (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars, which may require additional treatment or surgical repair at a later date
- Involvement of the nerves during removal of teeth, resulting in the temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity or pain
- Failure of the dental procedure, necessitating additional treatment
- Breakage of dental instruments inside tooth canals, making additional treatment necessary
- Complications during treatment, necessitating referral to a specialist

By signing this form, I agree with the following:

**I have read and understand the risks involved in receiving dental treatment, any alternative risks, as well as the consequences of doing nothing.

**I understand that I am responsible for any fee(s) involved.

**All of my questions have been answered and I have not been offered any guarantees.

**I authorize Dr. Erramouspe, hygienists and support staff to perform the necessary dental procedures.

**I consent to the dental office using my cell phone number to call or text me regarding appointments; and to call regarding treatment, insurance and my account. I understand that I can withdraw my cell phone consent at any time.

My CELL PHONE # is: _____

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Patient Signature _____*(Parent if under 18)*

Printed Name _____ Date _____

For the following minor child(ren): _____

_____

Witness _____ Date _____

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