Dental Health PC

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentists Matthew C. Schapper DMD and/or dental auxiliaries of their choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthetics, radiographs (x-rays) or diagnostic aids.

    A. Preventative hygiene treatment (prophylaxis) and the application of topical fluoride.
    B. Application of "sealants" to the grooves of the teeth.
    C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
    D. Replacement of missing teeth with dental prostheses. (bridges, partial dentures, full dentures)
    E. Removal (extraction) of one or more teeth.
    F. Treatment of diseased or injured oral tissues (hard and/or soft)
    G. Use of nitrous oxide to control apprehension or disruptive behavior.
    H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
    I. Use of local anesthetic to accomplish necessary treatment.
    J. Adjustment of the contours of teeth to correct malocclusion (poor bite position).

2. I understand that there are risks involved in dental treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthetic and/or the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor and hygienists. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece may leave an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, paresthesia, bleeding at or near the injection(s) site, fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research, scientific publications, and website as well as in office video screen.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose in writing to terminate it.

10. I understand that I have the right to deny such procedures after PARQ (Patient Advised of Risks and Questions were addressed). I knowingly take on all risks to my personal health with no liability to the dentist or any auxiliary when denying recommended dental treatment.

Patient's Name: _____ Date _____

Patient's Signature: _____

Parent Signature (if patient is a minor) _____