WESTSIDE DENTAL
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CONSENT FORM

Print Patient's Full Name Date of Birth

I hereby authorize ______________________________
Doctor's name

And whomever he/she may designate as his/her assistants, to perform upon me the following operation and/or procedures: Dentistry

I request and authorize him/her to do whatever he/she deems advisable if an unforeseen condition arises in the course of these designated operations and/or procedures, calling in their judgment for the procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages, disadvantages of the treatment, and consequences if this treatment was withheld.

I consent to the above treatment plan after having been advised of the alternative plans of treatment available and the known material risks, advantages, and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case and understand that there is a slight element risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, aspiration, thrombophlebitis (e.g., irritation or swelling of the vein), pain, discoloration, and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include postoperative bleeding, swelling or bruising, discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw, which might require extensive surgery removal.

I realize that despite the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science, and I acknowledge that there are no guarantees that have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions; receive answers to and get responsive explanations for all questions about my medical condition; and contemplate an alternative treatment, protocol, risk, and potential complications of the contemplated and alternative treatment and procedures prior to signing this form.

Patient or Legal Guardian Signature Date