Barnes Dental Care

# DENTAL TREATMENT CONSENT FORM

Providing the highest quality dental care involves keeping you informed so you can make good decisions about your dental health. Please read the following information carefully. It describes the treatment offered in our office. You have a right to ask questions about anything you don't understand. We will be pleased to answer your questions.

- Radiographs(xrays) of the teeth
- Cleaning of the teeth
- Application of topical fluoride for children
- Application of plastic "sealants" to the grooves of the teeth for children
- Use of local anesthesia to numb the teeth and tissues
- Treatment of diseased or injured teeth with dental restorations (fillings and crowns)
- Replacement of missing teeth with dental prostheses
- Removal (extraction) of one or more teeth
- Root canal Treatment
- Use of sedative drugs to ease apprehensiveness and use of nitrous oxide

I hereby authorize and direct the dentist assisted by other dental auxiliaries of his choice, to perform upon myself or my child (or legal ward for whom I am empowered to consent) the necessary dental treatment or procedures required to maintain my dental health. I certify that I have read and understand this consent form, that I have been given an opportunity to ask questions, and that all questions about the procedure(s) have been answered in a satisfactory manner. I am aware that the practice of dentistry is not an exact science and I acknowledge that no written or oral representations, warranties or guarantees have been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I understand futher that I have the right to be provided with answers to questions that may rise during the course of my treatment or that of my child. I futher understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

I have been advised that medications, drugs, anesthetics and prescriptions may cause drownsiness and lack of awareness and coordination; thus I have been advised not to operate any vehicle or hazardous device for at least 24 hours or until fully recovered from the effect of the anesthetic, medications and drugs that may have been given me for my care. I agree not to drive myself home, and to have a responsible adult accompany me until I am recovered from my medications.

Patient Name(Please Print)_______________________________________________

Signature of Patient or Legal Guardian______________________________________

Date__________________________

IF THE PATIENT IS LESS THAN 18 YEARS OF AGE

I, ______________________________, sign this form on behalf of and consent to the treatment explained above to be provided to _______________________________.