

## 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 questions about anything you do not understand. We will be glad to explain it to you.

1. I hereby authorize and direct **Cypress Creek Dental**, or any of its subsidizers, assisted by licensed dentist and or dental auxiliaries of their choice to perform upon me or my child \_\_\_\_\_ (name) the following dental treatment or oral surgery procedures including the necessary or advisable anesthesia, radiographs, (x-rays) or diagnostic aids.
2. In general terms, the dental procedures may include one or a number of the following:
  - a. Cleaning of the teeth and application of topical fluoride
  - b. Application of sealants to the groove of the teeth
  - c. Treatment of diseased or injured teeth with dental restorations. These restoration may either be amalgam(silver) or composite(white)
  - d. Stainless steel crowns for children. These are necessary in cases where simple fillings would not be the best long term restorations or in cases where there are large cavities.
  - e. The replacement of missing teeth with a dental prosthesis (crowns, partials, etc.)
  - f. Extraction (removal) of teeth that cannot be saved
  - g. Treatment of diseased or injured oral tissue(hard and / or soft)
  - h. Treatment of malposed(crooked) teeth and/or developmental abnormalities
  - i. Treatment of canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or (root canal treatment)
  - j. The use of sedative medication and/or nitrous oxide in 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. Alternative methods of treatment, if any, have been explained to me, as have the advantages and disadvantages of each. I am advised that good results are expected, however, the possibility and nature of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this 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 mine or my child's health, once treatment has been initiated.

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

I hereby state that I have read and fully understand this content. I have been given an opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time that I choose to terminate. Such termination of consent must be done in writing.

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Doctor