GENERAL CONSENT TO TREATMENT

1. I hereby authorize and direct the dentist(s) of Radiant Smiles Family Dental, PLLC and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, (x-rays), or diagnostic aids:

   A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
   B. Application of plastic 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 (extractions) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and/or soft).
   G. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.

2. I understand that there are risks involved in this 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 anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints and/or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves 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, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection 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 also authorize the doctor(s) to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

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(s). 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/her 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 to terminate it.

Patient name: _____

Patient signature: _____ Date: _____

Name of parent or guardian: _____

Relationship to patient: _____

Parent or guardian signature: _____

Witness signature: _____