TREATMENT AUTHORIZATION AND CONSENT

I hereby authorize Adiska Family Dental and whomever they may designate as their associates, and or assistants, to perform dental treatment upon me / my child

(Print Patient Name)_____

If for any unforeseen condition arises in the course of treatment calling for, in their judgment, procedures in addition to or different from those now contemplated, I further authorize and request Adiska Family Dental to do whatever they deem advisable.

The following information is not presented to worry you, but rather, in order to conform to the principles of **INFORMED CONSENT**. Any dental procedure or anesthetic may result in certain postoperative effects. These could include infection, postoperative bleeding, swelling and or bruising, Discomfort, stiff jaws. Less common complications can include loss of loosening of dental restoration, loss of or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. numbness In mouth, lips or tongue. Only in rare instances is this permanent), broken jaws, sinus exposure, swallowing or inhaling of teeth or restorations and injury to the ligaments or muscles of the jaw joint, (TMJ). The utmost care will be given to minimize the possibility of these complications.

I further consent to the administration of local anesthesia, antibiotics, or any other drugs that may be deemed necessary in my case, and I understand that there is a slight element of risk inherent in the administration of any other drugs or anesthesia.

I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, and will follow any and all postoperative instructions as directed and permit prescribed diagnostic procedures.

I further realize that in spite of the possible complications, my contemplated treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results or treatment.

I have read and understand the above explanation and I consent to treatment and the administration of anesthesia, and any other procedures which may be deemed necessary at the time of treatment. A full explanation of all complications is available to me upon request from the Doctor.

Print Name:_____

Signature Patient/Guardian:_____ Date:_____

(Parent or Guardian must sign for patients under 18)