Informed Consent for General Dental Procedures

I, **(print name)** _____, a patient of Abington Dental Associates, have been fully informed about the details of the recommended treatment and alternatives by the practitioners at Abington Dental Associates, as well as the matters described below (and including any additional information contained on any attached "Consent" form). I understand that I have the right to accept or reject dental treatment recommended by practitioners at Abington Dental Associates and acknowledge that prior to consenting to the recommended treatment by signing below, I have been fully advised of and I have carefully considered the anticipated benefits and possible known risks of the recommended procedure, alternative treatments, or the option of no treatment, as they are presented to me.

I have been advised and I understand that individual reactions to treatment cannot be predicted, and by consenting to the treatment, I am acknowledging my willingness to accept all risks and complications, no matter how slight the probability of occurrence.

I understand that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments at this office or with other recommended dentists or specialists, following all pre- and post-treatment home care instruction, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to the office any change in my health status. I understand that failing to follow the advice of my dentist may increase the chances of a poor outcome.

Please read the items below, initial where indicated, and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations	Crowns and Bridges	Radiographs
Preventative Services	Root Canal Therapy	Other
Restorations	Extractions	

Patient Initials_____

2. Drugs and Medications

I have been advised and I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). I will inform the office of any such known reactions to the best of my knowledge. I have advised the dentist of any and all medication of any type that I currently am taking, and I acknowledge that my failure to so advise the dentist may have unforeseen medical consequences for me.

Patient Initials_____

3. Local Anesthesia

I understand that there are some risks in the administration of local anesthesia. Most risks are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they might include loss of, or disturbed sensation of the tongue and/or lip on the side of the injection. If this occurs, it is often temporary, and normal sensation usually returns in several days. However, in very rare cases, the loss of sensation may extend for a longer period or become permanent. In addition, injection of a local anesthesia into the body may result in a rare allergic reaction.

Patient Initials_____

4. Changes in Treatment Plan

I have been advised and I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials_____

5. Photographs/Videos

I understand that the photographs and/or videos that may show my identity may be used as a record and in the facilitation of my dental care, and may be used by Abington Dental Associates for educational purposes in lectures, demonstrations and professional publications and I approve and authorize this use by Abington Dental Associates.

Patient Initials_____

6. Insurance Communication

I give permission to the dental office to communicate with and bill my dental insurance provider for any treatment provided to me, if applicable.

Patient Initials_____

I have discussed all of the above with the dental office and all of my questions have been answered to my satisfaction by the dental office. I acknowledge and understand that no guarantees or assurances have been given to me by anyone as to the results that may be obtained by the recommended treatment. In consideration of and with full knowledge and understanding of all of the foregoing, by signing below, I hereby consent to the recommended treatment and I authorize the dentist to proceed with recommended treatment.

Patient Signature **Date**

Witness Signature **Date**

If patient is under 18:

I, **(print name)** _____, am the parent/legal guardian of the individual named below. By signing this form, I acknowledge that I have completely read and fully understand this document and agree to be bound thereby.

Patient Name: _____

Parent/Guardian Signature **Date**

Witness Signature **Date**