

## CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist of Dr. Jana Oister and/or dental auxiliaries of her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anaesthesia, 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 (fixed bridges, removable partial or full dentures, implants).
  - E. Removal (extraction) of one or more teeth.
  - F. Treatment of diseased or injured oral tissues (hard and/or soft).
  - G. Use of sedative drugs to control apprehension and/or disruptive behavior.
  - H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
  - I. Use of general anaesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that this risk/s 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 anaesthesia and the use of nitrous oxide/oxygen analgesia 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 judgement of the dentist.
5. There are possible risks and complications associated with the administration of local anaesthesia, 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 either 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 doctors 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 instruction of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions to 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.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM File No. \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: Patient or Parent or Guardian \_\_\_\_\_

Witness: \_\_\_\_\_

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