The Dental Group, P.C.
DENTISTRY WHEN YOU NEED IT
3176 ABBOTT ROAD, BUILDING B, SUITE 600, ORCHARD PARK NY 14127
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GENERAL CONSENT FORM

Patient Name _____

(*Please print*)

I hereby authorize my dentist at The Dental Group, PC and whomever he/she may designate as his/her assistants and/or hygienists, to perform diagnostic, preventative and restorative procedures on me or my dependent. I further consent to the administration of any drugs that may be deemed necessary in my/my child's case, including but not limited to antibiotics and analgesics.

Benefits:

Receiving treatment will result in establishing better oral health.

Risks:

I am informed and fully understand that there are certain risks in any dental treatment. These risks include, but are not limited to: sensitivity of the teeth and gums following dental cleaning and gum treatment, post-treatment pressure, tooth temperature sensitivity, pain throbbing, jaw joint tenderness or pain after treatment.

I understand that there is a slight element of risk in the administration of any drug or anesthetic. This risk includes: pain, discoloration of skin due to injury of blood vessels, injury to nerves that may be temporary or permanent, allergic reactions, cardiac arrest.

Alternatives:

A more complete explanation of all complication is available to me upon request from the doctor.

Complications:

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

_____ _____

Signature of Patient or Responsible Party *Date* *Relationship to Patient (if not signed by patient)*

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Signature of Witness *Date*