GENERAL DENTAL TREATMENT CONSENT FORM

You, the patient, have the right to accept or reject dental treatment recommended by our office. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide us with accurate information before, during and after treatment. It is equally important that you follow the advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of our office, you may increase the chances of a poor outcome.

TREATMENT TO BE PROVIDED

I understand that during my course of treatment the following care may be provided: examinations, preventative services, restorations, crowns, bridges, extractions, root canals, dentures, implants and any other treatment deemed necessary. I do hereby authorize and request the performance of dental services and the use of whatever procedures may be deemed necessary for treatment. I understand that Boschetti Dental will use clinical and patient management techniques that are reasonable, necessary, and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed appropriate.

DRUGS AND MEDICATIONS

I understand that the administration of local anesthetics, antibiotics, analgesics and other medications can cause nerve damage and unexpected allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that potential complications include, but are not limited to pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

If you are prescribed an opioid for pain after a procedure performed in this office, please be advised of the following common side effects of opioid administration, which include: sedation, dizziness, nausea, vomiting, constipation, physical dependence, tolerance and respiratory depression. Physical dependence and addiction are clinical concerns that may prevent proper prescribing and in turn inadequate pain management. (www. ncbi.nlm.nih.gov/pubmed/18443635) Please be sure to contact your local police department to inquire about their Take-Back Day events to ensure unused medications are not misused or improperly disposed of.

CHANGES IN TREATMENT PLAN

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 dentists to make any/all changes and additions as necessary. I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise, that dictate additional procedures or treatment. I will always be advised of any changes.

INSURANCE

I give permission to Boschetti Dental to bill my dental insurance provider for the treatment provided, if applicable.

CELL PHONE USE POLICY

1. I provide consent to Boschetti Dental to use my cell phone number to (choose one or both) call or text regarding appointments.

2. I consent to Boschetti Dental to call using my cell phone regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

I voluntarily assume any or all possible risks that may be associated with any of these procedures. I understand it is my responsibility to diligently follow the instructions given to me in regard to my treatment.

_____ _____ _____

Patient's signature Print Name Date

(Guardian if patient is a minor)

For Guardians, please note your relationship to patient: _____