VER: 02/2014

BayView DENTAL Associates

expect something to smile about

ALL PHASES OF GENERAL DENTISTRY

I, _____ hereby authorize Bayview Dental Associates and whomever they may designate as his/her assistants to perform upon me the following operations and/or procedures for dental treatment. If any unforeseen condition arises in the course of the designated operations and/or procedures calling in their judgment for procedures in addition to or different from those now contemplated, I further request and authorize him/her to do whatever he/she deems advisable.

I consent to the proposed treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used, and the consequences if this treatment were withheld. I am informed fully and understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swellings or bruising, discomfort, stiff jaws, and loss or loosening dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissue, nerve disturbances (e.g. numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risks include adverse drug response (e.g. allergic reactions), cardiac arrest, aspiration and thromobophiebitis (e.g. irritation and swelling of a vein), discomfort, discoloration and injury to blood vessels and verves which may be caused by injections of any medications or drugs.

A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.

I realize that in spite of the possible complications, my contemplated surgery/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 of the operation/procedure(s). I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed, and permit prescribed diagnostic procedures.

I hereby authorize Bayview Dental Associates to use photographs of my case for presentation to other patients, students and staff for the purpose of education and information. I understand that only pictures of my teeth, not my entire face, will be used for this purpose.

_____ _____

Patient Signature **Date**

_____ _____

Signature of Witness **Date**