Distinctive Dental Service
Consent for Treatment

1. I hereby authorize and direct the dentist(s) of Distinctive Dental Service and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedures(s), including the use of any necessary or advisable local anesthesia, 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 restoratives (fillings and crowns).
    d. Replacement of missing teeth with dental restoratives (fillings and crowns).
    e. Removal (extractions) of one or more teeth.
    f. Treatment of diseased or injured oral tissue (hard and/or soft).
    g. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and risks, and the I fully understand the same.
3. I agree to use of local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves and 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 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 judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting bruising, tingling, and numbness of lip, 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 there 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 complication.
6. I also authorize the doctor(s) to use photographs, radiographs, other diagnostics materials and treatment records for the purpose 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/or parent follow post-operative and post care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care to be followed and that regular office visits 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 a time I choose to terminate it.

Date:_____

Patient's Name: _____

If minor, Parent/Guardian Name:_____

Patient or Patient/Guardian Signature:_____

Witness:_____