OZARKS COMMUNITY HEALTH CENTER

Dental Treatment Consent Form

Consent for X-rays

In providing the best possible dental care for you, we may need to expose and evaluate x-rays to help us with proper diagnosis. With use of a lead shield, dental x-rays provide minimal radiation exposure and provide valuable information necessary for your health.

____ Yes, I agree and accept x-rays for proper diagnosis.

Local Anesthesia Consent

I understand that local anesthesia is often used during the dental treatment. This consent form is designed to make you aware of the following risks involved with local anesthesia. These include but are not limited to:

- It may affect your body such as dizziness, nausea, vomiting, increase or decrease in heart rate, or allergic reactions, which may require medical management or hospitalization.
- Restriction in mouth opening called trismus, at the site of injection requiring physical therapy.
- Prolonged numbness sometimes causing injury from biting or chewing on areas such as lips, cheek, or tongue.
- Injury to nerves can result in pain, numbness, tingling, or other sensory disturbances to the chin, lips, cheek, gums, or tongue. This may persist for weeks, months, years, or very rarely permanent.

Treatment Consent

I authorize the dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a proper and thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist to perform all recommended treatments, procedures, and medication administrations as prescribed by the dentist and agreed upon by me, or my legal guardian, I understand that during treatment it may be necessary to change or add procedures because of conditions found while treating the teeth that were not discovered during the examination. I give my permission to the dentist to make any/all changes and additions as necessary.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient/Guardian Signature _____ **Date** _____

Patient Name (printed)_____

Witness Signature _____ **Date**_____