NORTHAMPTON DENTAL GROUP, P.C.

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Informed Consent for General Dental Procedures

I understand the purpose of this general consent is to inform me of risks and benefits that are common in many dental procedures.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although this carries with it its own risks.

I understand that during the course of my treatment the following care may be recommended or necessary: examinations, preventative services, restorations, crowns, bridges, or other. I understand that during treatment it may be necessary to change or add procedures due to 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 dentist permission to make any changes and additions to my treatment plan as necessary.

For routine fillings, dental cleanings, prescription of medications: I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, I understand that medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction, and I need to fully disclose all of my medications to my dentist and pharmacist; this includes herbal supplements.

For the administration of local anesthetic: I understand that for many treatments and procedures I will be given a local anesthetic injection which may cause an adverse reaction or side effects which may include, but are not limited to cardiac stimulation, bruising, muscle soreness, temporary or rarely permanent numbness, or temporary or permanent injury to nerves and/or blood vessels which may cause hematoma (blood that leaves the capillary and collects in a confined area). In a certain percentage of cases patients have had an allergic reaction to the anesthetic.

For oral surgery: I understand that there is always a risk of a post-operative infection, nerve damage, and iatrogenic injury, (an injury that might arise from our treatment or advice). In rare cases, the complications from surgery can be permanent, disabling, or even cause death. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation or breakage of dental instruments which may become lodged in a gum or other soft tissue or aspirated. I understand that occasionally needles break and may require surgical retrieval. Should I experience any of these or other conditions during or following treatment, I will contact my dentist as soon as possible.
I understand that my dentist can offer no guarantees or assurances as to the outcome or results of treatment or surgery.

I am consenting to radiographs prescribed by my doctor in reason with what is medically necessary to assess my dental health. I also consent to a general cleaning in the event I am not diagnosed with gum disease.

I understand that it is important to follow my dentist's advice and recommendations regarding medication, pre and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. My failing to follow the advice of my dentist, may increase the chances of a poor outcome.

I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications.

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

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care. I understand that some after-treatment effects and complications tend to occur with regularity.

_____	_____	_____
Patient's Name (Please Print)	**Patient's Signature**	**Date**