<u>Consent for Dental Treatment</u>

State Law requires us to obtain your consent for dental treatment. Please feel free to ask any questions you may have. In general terms, contemplated treatment is: dental restorations, sealants, extractions, exam, cleaning, local anesthetic, and nitrous oxide.

Alternatives to the Recommended Dental Treatment
Any alternatives to the recommended treatment, including no treatment, have been explained to me, as have the advantages and disadvantages of each.

Risks associated with the Recommended Dental Treatment
I understand dentistry is not an exact science and complications may occur despite our best efforts. A partial listing of the risks known to be associated with dental treatment and anesthetic care are:

> Infections, Bleeding, Failure of wound to heal, Injuries to adjacent teeth or soft tissues, Paresthesia or numbness of tongue, mouth or face, Fracture of Lower jaw or Upper Jaw, opening between mouth and sinus or mouth and nose, Incomplete removal of tooth, Dry socket, Loss of teeth, Loss of bone, Loss of hard or soft tissues, Instrument breakage, Breakage of roots and retained root fragments, Swallowing or aspiration of objects, Allergic reactions to drugs, Jaw Pain or difficulty opening mouth, Bacterial Endocarditis, Additional Oral Surgery, Hospitalization, or further treatment upon complications.

State law also requires the we specifically advise you that, although rarely occurring, dental treatment or anesthetic may result in: Death, Brain Damage, Paraplegia, Quadriplegia, Loss of Organs, Loss of Function of an Organ, Loss of function of Face, Arms, Legs, and Disfiguring Scars.

<u>Acknowledgment</u>

I have read and understand the information stated above. I have been given ample opportunity to ask any questions I may have about treatment. All questions have been answered in a satisfactory manner. I understand the success of this treatment and the avoidance of treatment complications depends upon my complying with the instructions, restrictions, and any recommendations, that have been explained to me. I also understand that I am to notify the dentist immediately of any suspected complications, where further treatment may be discussed or administered, which is not currently anticipated.

I, as the patients legal guardian, authorize and request **Dr. Joseph A. Yale, Dr. Mary K. McClendon, Dr. Kathleen Corbin** and/or assistants of his choice, to perform any dental procedures, including anesthetic, that deem necessary during treatment. I understand the treatment plan to be presented, along with the fees outlining, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. **By signing this I agree to be responsible for full payment of all charges on the above named patient.**

This consent will remain valid until revoked in writing. All blanks have been filled in prior to my signature.

Patient Name____

Guardian
Signature____date_____________