

# CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentists of Barrett L. Bartell, D.D. S., P.A. and/or dental auxiliaries of his choice, to perform the following dental treatment including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids; as well as any of the following:

- 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 restorations, (fillings and crowns, root canal therapy).
- D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures, implants).
- E. Removal (extraction) of one or more teeth.
- F. Treatment of diseased or injured oral tissues (hard and/or soft).
- G. Use of sedative drugs to control apprehension and or disruptive behavior.
- H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
- I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in all treatment and hereby acknowledge that these risks will be explained to me, and that I will have an opportunity to ask questions regarding the treatment and the risks of the treatment to be performed.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an 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. 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 the lips, 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 in 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 complications.

5. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. The doctor (s) will discuss the additional treatment before proceeding with treatment. 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.

6. I also authorize the doctors to use photographs, radiographs, and/or other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I am advised, and agree, that the success of the dental treatment provided requires adherence to post-operative and post-care instructions provided by the doctor (s). I also agree that regular office visits as scheduled by my dentist and his 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. I also understand that this consent will remain in effect until such time as I choose to terminate it.

Date: \_\_\_\_\_ Patient's Name Printed: \_\_\_\_\_

Name of Parent (or Guardian) if child: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature: Patient or Parent/Guardian

\_\_\_\_\_  
Staff Signature as witness of consent

\_\_\_\_\_  
Doctor Signature