

# INFORMED CONSENT

I hereby authorize Dr. Dyer and his assistants, and/or hygienists, to perform upon me the dental procedures that we discuss. If any unforeseen condition arises in the course of designated procedures calling, in his judgment, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he deems advisable.

I understand that there are certain risks in any dental treatment. These risks include, but are not limited to, post-treatment pressure and temperature sensitivity, pain, nerve inflammation, and sensitivity of teeth and gums during and following dental treatment. Other less common risk include but are not limited to, infection, injury to adjacent teeth and gums, swallowing or aspiration of a part of a tooth or filling and nerve disturbance (e.g. numbness in mouth and lip tissues). These complications that result form these risks may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drugs or anesthesia. This risk includes, but is not limited to, following complications; adverse drug response (e.g. allergic reactions), irritation and swelling of a vein, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

A more complete explanation of all risk and complications is available to me upon my request from the doctor.

In spite of the possible complications and risks my treatment is necessary and desired by me.

DATE	PATIENT/PARENT/GUARDIAN SIGNATURE	DOCTOR/STAFF
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