Alan I. Burch, D.D.S.
Julie A. Alter, D.M.D.
General Consent Form

Please read carefully, if you have any questions we will be glad to answer them for you.

The following is a required consent for contemplated or proposed dental treatment.

1. I, hereby authorize any dentist, dental assistant and/or dental hygienist in this office to perform upon me, or my child the following dental treatment or oral surgery procedure including the necessary or advisable local anaesthesia, radiograph (X-rays) or diagnostic aids.
2. In general terms, the dental procedures may include one or a number of the following:
    - Cleaning of the teeth, and application of topical fluoride and desensitizers.
    - Application of sealants to the grooves of teeth.
    - Treatment of diseased or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white). The replacement of missing teeth with a dental prosthesis (crown, bridges, partials, implants).
    - Extraction (removal) of one or more teeth that cannot be saved.
    - Treatment of diseased or injured oral tissues (hard or soft).
    - Endodontic treatment (root canal).
    - The use of sedative medications and/or nitrous oxide to control apprehension and or disruptive behavior.

    One or more treatments will be performed after previously discussing with me the necessity and obtaining my verbal consent to proceed. Alternative methods of treatment if any will be explained to me, as to the advantages or disadvantages of treatment. I am advised that good results are expected. However, the possibility and nature of complications cannot be accurately be anticipated. Therefore, no guarantee, expressed or implied can be given to me regarding any dental treatment. I further understand and authorize the doctor to perform any necessary treatment that in his/her judgement will be in my best interest, or that of my child (if my child is the one being treated), once treatment has been initiated.
    Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedures, medications and/or anaesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of

organs, scarring. I understand and accept that any complications may require medical assistance, hospitalization, and in very rare cases death.

I hereby state that I have read and fully understand this consent. I have been given the opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time that I choose to terminate treatment. Such termination of consent must be in writing.

Patient name_____

Signature of Patient/Guardian_____