141 Communications Dr.
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INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

Patient: ______________________________________ DOB: ___________

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

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Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so s/he can consult with your physician if necessary.
The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Dental Procedures: The above named patient, (or________________________ parent or legal guardian of the named patient), authorizes Clarity Healthcare and its dental staff to perform the following dental procedures and/or treatment on the patient, including, but not limited to: dental examination, dental prophylaxis, fluoride treatment, x-rays, restorations, periodontal therapy such as scaling and root planing, primary tooth pulpal therapy, placement of stainless steel crowns, extractions, alveoplasty, crowns, bridges, endodontic therapy, frenulectomy, space maintenance, fabrication of removable appliances, and _______________.

Risks of Procedure: Include, but are not limited to pain, swelling and discomfort, infection, bleeding, nerve injury, numbness, blood clots, broken or cracked teeth, soreness of the mouth, lips, gums, and teeth, allergic reactions, fever, nausea, and vomiting.

Occupational Exposure: I consent to the withdrawal of a blood sample from me or the above-listed patient to perform tests which include, but are not limited to, HIV and Hepatitis antibodies. I understand that the blood test will be done only if a healthcare worker has an accidental needle stick or mucous membrane exposure to the blood and bodily fluid of the patient. I understand that the test will be done on the order of my or the above-listed patient's medical team and the results will be released to the dentist. I will receive no report or discussion from the Clarity Healthcare dental clinic concerning these tests. I authorize the release of the appropriate data necessary to process the testing. I understand that there will be no cost to me for this blood test.

No Guarantee: I understand that no guarantee or assurance has been made as to the ultimate result of any procedure.

Advance Directives: Clarity Healthcare will not withhold emergency care from any patient at its clinics despite the existence of an advance directive or the verbal instructions of the patient.

Publication of Records: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either the advancement of dentistry or educational materials. My identity will not be revealed to the general public.

Patient's consent: This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment and signing this Informed Consent.

______________	____	____________________________________
Date	Patient or Patient's Guardian Signature	Relationship to Patient
______________	____	____________________________________
Date	Witness Signature	Interpreter Name
______________	____	
Date	Dentist Signature	