GENERAL CONSENT FOR DENTAL PROCEDURES

Patient Name: _____ Date of Birth: _____

REGARDING MY MEDICAL HISTORY:

_____ (INITIALS) I certify that the answers to the health and dental questionnaires are accurate and correct to the best of my knowledge. I understand that a change in medical or dental condition(s) or a change in medication(s) may affect my dental treatment. I agree to notify Dr. Casement or any associates or employees of any changes that may occur.

REGARDING GENERAL CONSENT TO DENTAL PROCEDURES:

_____ (INITIALS) I do hereby authorize and request the performance of dental services by Dr. Casement and such associates or employees they may designate, and the use of any procedures Dr. Casement or staff may deem necessary or advisable to maintain my dental health, the dental health of any minor or other individual for which I am legally responsible for. I understand that treatment options will be explained to me so that I may make an informed decision regarding my dental care or the dental care of a minor or dependent.

REGARDING ANESTHESIA:

_____ (INITIALS) I understand that anesthetics may be used for therapeutic, diagnostic, or treatment purposes. I authorize for myself, and any minor or other individual for which I have legal responsibility, the administration of any anesthetics, analgesics or sedatives, including without limitation, therapeutic and/or other pharmaceutical agents (including those related to restorative, palliative, therapeutic, or surgical treatment) that may be deemed appropriate by Dr. Casement, associates or employees. I understand that antibiotics, anesthetics, analgesics and other medications may cause complications and reactions including without limitation allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I also understand that additional complications may include, but are not limited to, pain, swelling, bruising, temporary limited opening, hematoma, cardiac stimulations, reduction in the effectiveness of birth control, muscle soreness, temporary or permanent numbness, and local infections. I further understand that on occasion anesthesia may be prolonged and in very rare cases, permanent. I understand that I may also request that no anesthetic be used at the time of treatment for myself, or any minor or dependent that I am legally responsible for.

REGARDING DENTAL TREATMENT:

_____ (INITIALS) I understand that any treatment plans presented, along with the fees outlined, could change depending on the extent of dental pathology and the time elapsed since the initial examination. I understand that once the treatment phase has begun, complications may arise that dictate additional procedures or treatments not limited to root canals, crowns, extractions and/or implants. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I authorize Dr. Casement to make any and all changes and additions as necessary. I further understand that any changes in treatment will be explained to me so I may make an informed decision regarding my dental care or the care of a minor or dependent.

_____ (INITIALS) I understand that a more extensive treatment plan than originally discussed, including but not limited to root canal therapy, crowns, and/or surgical therapy (extractions and implants) may be required due to additional conditions discovered during or after dental treatment.

CONSENT: *I have had the opportunity to have all my questions answered by Dr. Casement, associates or employees thereof, and I certify that I understand English. My signature below signifies that I understand that the recommended treatment and anesthesia will be explained to me together with the known risks and complications associated with such treatment. I hereby give my consent for any dental procedures, anesthesia and treatment thereof by Dr. Casement and associates or employees.*

Patient / Guardian Signature: _____ Date: _____

Printed Patient / Guardian Name: _____

Relationship to patient: _____