MID-STATE HEALTH CENTER
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INFORMED CONSENT: DENTAL SERVICES

I hereby give consent for myself/ my child to receive treatment deemed necessary by the dental providers at Mid-State Health Center. These procedures may include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, extractions, and the use of local anesthetics.

I understand my/ my child's dental condition(s) and have discussed treatment options with my/ my child's provider. I will be given a printed copy of the treatment plan.

I understand there are risks inherent in general dental treatment(s). The potential risks and complications, include, but are not limited to, the following:

- Drug reactions and side effects.
- Damage to adjacent teeth or tooth restorations.
- Necessity for further treatment based on findings during treatment (like a pulp exposure, further decay, or unsupported tooth structure) or as a result of treatment.
- Breakage or dislodgement of filling material.
- Tooth sensitivity
- As a result of injection of local anesthesia, there may be swelling, bruising, jaw muscle tenderness, allergic reaction, numbness, tingling, changes in pain perception (that in rare cases may be permanent), and/or prolonged anesthesia.

I understand that each dental procedure or course of treatment has an expected result. I further understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to refuse treatment of any kind and I am aware of the possible consequences of non-treatment.

I understand that I have an electronic dental record that is separate from my medical health record. I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures to the best of my knowledge. I understand that withholding any medical information may affect the outcome of my dental procedure(s) or course(s) of treatment.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I give my consent for the administration of any medication that may be required as a life-saving measure.

I understand that fees are due at the time of service and I am responsible for paying all fees that are not covered by my insurance. All fees and insurance information have been explained to me.

I understand that this consent shall be considered in effect until rescinded or revoked in writing by the patient, parent, or legal guardian.

I have had the opportunity to discuss the risks and benefits of receiving dental treatment(s) with my/ my child's provider and/ or treatment team and all of my questions have been answered to my satisfaction. I hereby consent to dental treatment.

_____	_____	_____
Print Patient Name	Signature of Patient/ Legal Representative/ Guardian	Date

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Authority/ Relationship of Representative to Patient

Reviewed: 9/1/2020 kjp/rje