



GENERAL CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the office of Michael L. Chandler D.D.S. to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, or diagnostic aids:
 - Consult with examination for future treatment.
 - Preventive hygiene treatment (prophylaxis), and the application of topical fluoride.
 - Application of plastic “sealants” to the grooves of the teeth.
 - Treatment of diseased or injured teeth with dental restorations (fillings, crowns, and onlays).
 - Treatment of diseased or injured teeth with endodontic (root canal) therapy if needed.
 - **Breakage of dental instruments inside tooth canals requiring additional treatment.
 - Replacement of missing teeth with dental prostheses (i.e. implants, bridges, partials, and full dentures).
 - Removal (extraction) of one or more teeth.
 - **Involvement of the nerves during oral surgery or administration of local anesthesia resulting in temporary or possible permanent numbness or tingling of the lip, chin, tongue, or other areas of the face or neck.
 - **Sinus involvement during the removal of upper molars, which may require additional treatment or surgical repair at a later date or by an oral surgeon.
 - **Incomplete removal of tooth fragments to avoid injury to vital structures such as nerves or sinus, occasionally small root tips may be left in place.
 - **Jaw fracture- While quite rare, it is possible in difficult or deeply impacted teeth.
 - Treatment of diseased or injured oral tissue (hard and/or soft).
 - Use of sedative drugs to control apprehension and/or disruptive behavior.
 - Treatment of malposed (crooked) teeth and/or oral development of growth abnormalities.
2. I understand that there are risks involved in this treatment, and hereby acknowledge that these risks will be explained to me. I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient to follow post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performances of any additional procedures that are deemed necessary for desirable oral health and well being, in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose, which disappears shortly after procedure. I understand and have been informed of the above risks and complications.
7. I also authorize the doctor to use anonymized photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific publications.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided an answer to the questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

(x) _____ (x) _____
 Print Patient’s Name Print Name of Parent or Guardian (if applicable)

(x) _____ (x) _____
 Signature of Patient or Parent/Guardian Date Witness Signature Date