CONSENT TO DENTAL TREATMENT

I authorize the doctors, hygienists and/or assistants of Virginia Dental Solutions to perform those procedures deemed necessary or advisable to maintain my dental health or any minor or other individual for which I have responsibility. This includes the arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutic agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary, or rarely, permanent numbness.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry as well as fillings of all types, teeth may remain sensitive both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open in a predisposed patient can cause temporary jaw discomfort. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures.

I understand the need to disclose to the doctor, hygienist, or assistant any prescription drugs that are currently being taken or that have been taken in the past. I will also disclose any and all allergies/reactions to medications and/or foods (shellfish, nuts, etc.). I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complications of non-healing jaw bones following oral surgery or tooth extractions.

I do voluntarily assume all possible risks which may be associated with preventive and operative treatment procedures. I acknowledge that the nature and purpose of the procedures have been explained to me and I have been given the opportunity to ask questions.

PATIENT NAME:_____

SIGNATURE:_____DATE:_____

(Patient, legal guardian or authorized agent of patient)

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