Informed Consent

I understand that by signing below and initialing any of the following items that I request and authorize the procedure to be done and have read and understand the possible risks and complications of the procedure(s).

Initials _____

1. **X-rays and Examination**: I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken on my teeth that I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant radiation exposure poses a serious threat to the life and health of my unborn child. Pregnant women are required to have medical release from their Medical Doctor prior to X-rays and Dental Treatment. Initials _____
2. **Changes in Treatment Plan**: I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the dentist to make any and/or all changes and additions as necessary.
   Initials_____
3. **Drugs and Medication**: I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. Initials_____
4. **Fillings**: I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being done.
   Initials_____

Signature of Patient_____ Date_____

Signature of Doctor_____Date_____