DENTAL EXCELLENCE OF
Hatfield

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct Jessica Scordamaglia, D.M.D. and Dilip Dudhat, D.M.D. and or dental auxiliaries of his/her choice to perform the following dental treatment or oral surgery procedures(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids **after thorough review and my consent for treatment**.

A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Application of protective "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
D. Removal (extraction) of one or more teeth.
E. Treatment of diseased or injured oral tissues (hard and/or soft).
F. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves and indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications and understand **these will be reviewed with me for consent prior to treatment being rendered.**

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 performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist **after thorough review and final consent from me as the patient.**

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 and 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 **and will approve use of these if treatment must be performed.**

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications, and case presentations. _____ Initials

7. I do **NOT** authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications, and case presentations. _____ Initials

8. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist/s. 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/her auxiliaries must be maintained.

9. 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 answers to questions which may arise during and after the course of my treatment.

10. I further understand that this consent will remain in effect as long as I am a patient at Dental Excellence of Hatfield and **no treatment will be performed prior to authorization from patient, parent or caregiver.**

Date: _____

Patient's name: _____

Signature: _____

Witness: _____