HOLT FAMILY DENTISTRY
Sheila Gordon-Holt, D.D.S., P.A.

INFORMED CONSENT

PATIENT NAME: _____

I hereby authorize my Dentist, Dr. Sheila Gordon-Holt and whomever she may designate as her assistants and/or hygienists, to perform upon my future dental procedures which will be discussed. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize whatever she deems advisable.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post –operative pain and throbbing, swelling and re-infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings. (Initial)_____

The most common of these complications in oral surgery include post- operative bleeding, swelling or bruising, discomfort, stiff jaws, and loss or loosening of dental restorations. Other less common complications include, but are not limited to: infection, loss or injury to adjacent teeth and soft tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, nerve disturbances (e.g. numbness in mouth and lip tissues), and small root fragments remaining in the jaw which might require extensive surgery for removal. These complications may be temporary or permanent.

(Initial)_____

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis, (e.g. irritation and swelling of vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

(Initial)_____

A more complete explanation of all complications is available to me upon my request from the Doctor.

(Initial)_____

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

(Initial)_____

Date	Patient/ Parent/ Guardian Signature	Doctor/Staff
__/__/__	_____	_____