BIRCH
FAMILY DENTAL
Family & Cosmetic Dentistry

General Consent for Dental Treatment

We are required to obtain your consent for the proposed dental treatment or oral surgery. Please read this form carefully, and we encourage you to ask us anything that you do not understand. We will be glad to explain it to you.

I hereby authorize and direct Birch Family Dental and Bryant P. Birch, DDS, P.C. to perform upon me or my child, First:_____Last:_____, the following dental treatment of oral surgical procedures including the necessary or advisable local anesthesia, radiographs, or diagnostic aids.

In general terms, the dental procedures may include on or a number of the following:

- Cleaning of teeth and application of topical fluoride.
- Treatment of periodontal disease with deep cleaning, gum surgery, and bone/soft tissue grafting.
- Application of sealants to the grooves of teeth.
- Treatment of diseased of injured teeth with dental restorations, either amalgam or composite.
- Stainless steel crowns for children, which are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities.
- The replacement of missing teeth with a dental prosthesis (crown, bridge, partial/complete dentures, implants etc.)
- Extractions (removal) of one or more teeth that cannot be saved.
- Treatment of diseased or injured oral tissues (hard or soft).
- Treatment of overlapped teeth and/or developmental abnormalities.
- The use of nitrous oxide to control apprehension and anxiety.

I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed. Alternative methods of treatment, if any, along with their advantages and disadvantages have been explained to me. I am advised that good results are expected: however, the possibility of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I fully understand and authorize the doctor to perform any necessary treatment that in his/her judgment will be in the best interest of my or my child's health, once treatment has begun.

Although their occurrences are rare and unpredictable, some risks are known to be associated with dental or oral surgical procedures, medications, and/or anesthetic. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, and scarring. I understand and accept that complications may require medical assistance and hospitalization.

I also understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the gums or teeth that were not discovered during examination. The most common being the need for root canal therapy following routine restorative procedure. I give my permission to the dentist to make any/all changes and additions as necessary,

I certify that I have read and fully understand this consent. I have been given the opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time I choose to terminate. Such termination of consent must be in writing.

Patient/Parent/Guardian
Signature:_____Date_____

Witness:_____Date_____