

# Woodyard Dental Care

## General Informed Consent

I understand the recommended treatment and my financial responsibility has been explained to me. I understand that by signing this consent I am in no way obligated to treatment. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination.

I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and or anaphylactic shock.

I have provided as accurate and complete a medical and personal history as possible; including antibiotics, drugs or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays. I realize that in spite of the possible complications and risk, my recommended treatment is necessary.

I understand that in the situation where a dental procedure is completed, unforeseen complications may occur due to the extent of the decay and anatomical considerations specific to the patient. Also, while local anesthetic is very safe, complications may occur with its use including lingering numbness and altered taste.

I am aware that Woodyard Dental Care strives to provide the highest quality dentistry possible. However, despite their high degree of care, skill, & judgment, unforeseen problems can occur. While every effort will be made to correct any problems, I am aware that no guarantees, warranties, or representations have been made concerning the results of the treatment.

**I wish to proceed with the recommended treatment.**

Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Staff \_\_\_\_\_ Date \_\_\_\_\_