

GENERAL INFORMED CONSENT FOR DENTAL PROCEDURES OR ANESTHESIA

This is my given consent for Dr. Cady or any other dentist or physician who may be necessary to perform the oral, maxilla-facial, and/or dental procedures indicated on my examination chart and any other procedure deemed necessary.

I have been informed and understand that occasionally there are complications that can occur with any dental procedure including surgery, anesthesia, and/or medications. These include but are not limited to the following:

- Postoperative discomfort and swelling
- Heavy bleeding that may be prolonged
- Postoperative infection requiring additional treatment
- Bruising or discoloration at the injection site
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue on the treated site; this may persist for weeks, months, or in remote instances permanently
- Stiffening of the neck and facial muscles
- TMJ injury secondary to treatment, especially when TMJ symptoms pre-exist
- Change in occlusion
- Injury to adjacent teeth, restorations in other teeth, and injury to other tissues
- Referred pain to the ear, neck and head
- Nausea and vomiting or allergic reaction
- Oral/Sinus openings with delayed healing and possibly requiring additional surgery
- Decision to leave a small piece of the root in the jaw when its removal would require extensive surgery

Anesthetics, medications and prescriptions may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised to not operate any vehicle or hazardous device for at least 24 hours or until fully recovered from the effect of the anesthetic or medications that may have been given to me for care.

During the course of treatment, unforeseen conditions may be revealed that necessitate an extension of the original procedure or a different procedure than first planned. I therefore authorize Dr. Cady any any other necessary doctors and their assistants to perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known at the time original procedure is commenced.

All postoperative instructions will be explained to me along with receiving written instructions. I will arrange for a postoperative appointment visit if necessary and I understand that a perfect result or cure is not guaranteed or warranted and cannot be guaranteed or warranted. I also understand that I may ask for a full recital of all possible risks attendant to phases of my care just by asking.

Patient/Parent Signature

Date

Office Representative Signature

Date