Consent For Use of Local Anesthetic and Dental Treatment
William Swedenburg, D.D.S.

Date: ___________________

Name: ____________________________

The following is provided to inform our patients of the choices and risks involved with dental treatment. This information is not presented to make patients more apprehensive but to enable them to be better informed concerning their treatment. The choices for dental care include but are not limited to: examinations, xrays, prophylaxis, periodontal therapy, periodontal surgery, general anesthesia, extractions, fillings, crowns, implants, bridge work, endodontic treatment, prosthetics, etc. These treatments can be administered, depending upon each patient's medical requirements, either in an office or in a hospital setting, using dental equipment and technology approved by the dental board.

I, «FName» «LName», hereby authorize and request Dr. Swedenburg to perform dental treatment as previously explained to me and any other procedure deemed necessary or advisable as a corollary to the planned treatment. I consent, authorize, and request the administration of any necessary local anesthetics and any recommended dental treatment by any performance that is deemed suitable by the doctor.

I have been informed and understand that occasionally there are complications of anesthetics including but not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, fluctuations in breathing pattern, heart rate, and/or blood pressure, brain damage, coma, or death.

I have been informed and understand that occasionally there are complications of dental treatment including but not limited to: pain, tooth loss, tooth fracture, nerve or pulp damage, swelling, infection, bleeding, discoloration, numbness, brain damage, coma, or death.

I further understand and accept the risk that complications may require hospitalization. I have been made aware that the risks associated with local anesthesia vary. Local anesthesia is usually considered to be the least risk. However, it must be noted that local anesthesia sometimes is not appropriate for every patient and every procedure.

I understand that anesthetics, medications, drugs, and x-rays may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the doctor of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the treatment. For the same reasons, I understand that I must inform the doctor if I am a nursing mother.

I have been fully advised and completely understand the risk of dental treatments and anesthetics that may be provided to me today and in any future appointments, and I accept the risks and dangers. I acknowledge that I may request both pre-operative and post-operative dental instructions as I feel necessary. It has been explained to me and I understand there is no warranty to guarantee as to any result and/or cure. I have had the opportunity to ask questions about my dental treatment and anesthetics and am satisfied with the information provided to me.

Signed____ Date __________________
Patient or Guardian ____