Dennis J. Carlile DDS and Associates

**CONSENT TO PERFORM DENTISTRY**

1. I hereby authorize and direct the dentist(s) of A Family Dentist, Dennis J. Carlile D.D.S, Jason A. Knapp D.D.S, Mitchell Hoopes D.D.S. and dental auxiliaries to perform the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays),or diagnostic aids.

A. Preventative hygiene treatment (prophylaxis) and the application of topical fluoride
B. Application of plastic "sealants" to the grooves of the teeth
C. Treatment of diseased or injured teeth with dental restorations (fillings, crowns, bridges, veneers)
D. Replacement of missing teeth with dental prostheses (fixed bridges, removable partial or full dentures, implants)
E. Removal (extraction) of one or more teeth
F. Treatment of diseased of injured oral tissues (hard and/or soft)
G. Use of sedative drugs to control apprehension and/or disruptive behavior
H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities

2. I understand that there are risks involved in this treatment and hereby acknowledge that the risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of oral anxiolytics depending on the judgment of the doctor.

4. I recognize that during the course of treatment performed events may occur that necessitate additional or different procedures from those discussed, I therefore authorize the Doctors at A Family Dentist and their associates/auxiliaries to perform any additional procedures that are deemed necessary or desirable to oral health under the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are slight bleeding and pain at injection sites, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions to the medicines, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in injury to the oral mucosa. I also understand that there are rare potential risks such as unfavorable reactions resulting in respiratory arrest and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents/guardian if the patient is a child, follow post-operative and post-care instruction of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions to be followed and that regular office visits as scheduled by my dentist and her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

**Patient Name: _____**

**MINORS ONLY - Name of Parent or Guardian:_____ Relationship to patient_____**

**Address: _____**

**_____ State: _____ Zip: _____**

**Phone number (HOME) _____ (WORK) _____ (CELL) _____**

**Email Address:_____**

**I WOULD YOU LIKE TO BE CONTACTED BY: (PLEASE CIRCLE) TEXT MESSAGE - E-MAIL**

**Signature: _____Date:_____/_____/_____Time: _____ am/pm**