NEW ORLEANS DENTAL CENTER
CONSENT FOR TREATMENT AND PATIENT RESPONSIBILITY

The doctors and staff feel confident in the thorough explanations we give regarding the treatment that we recommend. We are always happy to explain anything, as many times as needed. Because every body is different, with different immune system health and unique reactions, there are risks associated with any dental treatment. These include the administration of any local or general anesthetic agent, medications to produce conscious sedation, and/or pre-medication prior to dental treatment. Some of the risks/complications are, but are not limited to, the following:

- Infection and/or swelling
- Allergic or other reactions to drugs or medicaments (such as nausea, vomiting)
- Bleeding
- Bacterial endocarditis
- Instrument breakage
- Dry socket
- Trismus (jaw pain or difficulty opening mouth)
- Paresthesia (numbness of face and/or mouth and/or tongue)—usually transient but could be permanent
- Opening between mouth and sinus or mouth and nose
- Failure of treatment to accomplish main purpose
- Loosening or additional spacing of teeth
- Changes in occlusion (biting/chewing)
- Delay or failure of healing of surgery site
- Injuries to adjacent teeth, restorations and/or hard/soft tissue
- Loss of teeth and/or bone
- Incomplete removal of tooth/root
- Swallowing or aspiration of objects
- Tooth or fragment(s) in maxillary sinus
- Breakage of root(s) and/or retained root fragment(s)
- Fracture of mandible (lower jaw) or maxilla (upper jaw)
- Jaw muscle cramps or spasms
- Increase in existing TMJ (jaw joint) dysfunction, known or unknown
- Sloughing (unanticipated loss of soft tissue and/or bone)
- Pain referred to ear/neck/head
- Death (extremely rare)

Additional oral surgery, hospitalization, and/or further treatment may be required in the event of any complication(s). Be assured that we are careful to minimize the potential for any risks associated with dental treatment.

I understand that it is my responsibility for payment of dental services provided for my dependents or me, due and payable at the time of services rendered, unless prior financial arrangements have been made, and regardless of any presumed insurance benefit. Any fees quoted are valid for six (6) months from the date of the treatment plan. **No refunds for professional services rendered will be given.**

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this form. I was given adequate opportunity to ask any questions and all questions were answered to my satisfaction. I hereby authorize the dentist and/or associates, hygienists, assistants of their choice to perform for_____ the diagnostic, surgical, orthodontic and/or dental treatment agreed upon between the doctor and the patient or parent/guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. This consent form will remain valid unless revoked by me in writing.

_____ _____

Patient's or Parent/Guardian's Signature Date

_____

Witness