STONY SPRING FAMILY DENTAL

David W. Hammer, D.M.D.

# CONSENT TO PERFORM DENTISTRY

I, _____ , hereby consent to and authorize Dr. David Hammer DMD, and/or his dental affiliates and assigns, to provide and perform any or all of the following dental treatment procedures, including oral surgery, in conjunction with the use of any necessary or advisable radiograph and other diagnostic aids as he deems useful.

1. Preventive periodontal care and maintenance, including topical fluoride application when beneficial;
2. Application of unfilled resin material, known as "sealants", to the occlusal (bite) grooves of the posterior teeth as a preventive treatment against tooth decay;
3. Treatment of the soft tissues (gums) in the presence of acute or chronic periodontal disease and/or injury;
4. Treatment of diseased or injured hard tissues, including teeth with suitable dental restorations (fillings or crowns), root canal therapy, or limited oral surgery (including tooth extraction) as circumstances require;
5. Replacement of missing teeth with dental prostheses using fixed and/or removable appliances (bridgework, partial or full denture / implant restoration);
6. Non-surgical evaluation / treatment of the temporomandibular joint, myofacial pain, and/or occlusal dysfunction, including the use of bite splint therapy, and limited or full mouth adjustment / equilibration;
7. Use of conscious sedation techniques (nitrous oxide analgesia; oral medication) to control and manage anxiety or disruptive behavior.

- I understand and accept that there are inherent risks associated with any dental treatment and hereby acknowledge that these risks have / will be explained to me, that I will have the opportunity to ask questions regarding the recommended treatment and its associated risk, and I am satisfied with the explanation given.

- I understand that there are potential risks and complications associated with the use of local anesthesia, nitrous oxide analgesia, and oral sedative medications, including allergic reaction (itching, tissue rash, breathing difficulty), pain, swelling, bleeding, bruising, hematoma (blood bruise at or near injection site), nausea, vomiting, tingling and/or numbness in area of anesthetized tissues subsequent to treatment for an indeterminate length of time, fainting, and biting of the soft tissues while numb resulting in ulceration / inflammation. I also understand that in rare circumstances the risk may include severe respiratory and cardiovascular complications, including total collapse (stopping of breathing and heart function; oxygen deficiency to the brain leading to possible coma or death). I acknowledge that I have been informed of such risks.

- I understand that during the course of treatment it may be necessary to alter and/or amend the prescribed treatment due to unforeseen circumstances that could not be anticipated earlier. In such cases, additional treatment will be explained. I authorize the performance of any additional treatment procedures that are deemed necessary according to the professional judgment of the dentist, after treatment has been explained.

- I understand and am advised that the overall success of any recommended dental treatment requires that the patient (and parents in the case of a minor) adhere to any and all post-treatment care instructions given by the dentist and/or the dental auxiliaries. In addition, the maintenance of regular re-care visits as scheduled will directly affect the long-term success of any treatment that is given.

- I understand and authorize the dentist, his dental auxiliaries, and assigns to use any radiograph, photograph, and other diagnostic materials / treatment records for the purpose of teaching, research, and scientific publication.

- In conclusion, I hereby state that I have read and understand this consent, that all questions with regard to dental procedures have been / will be answered to my satisfaction, and that I may require additional information whenever I deem it necessary to make an informed decision concerning my dental care. I further acknowledge and agree that this "consent to perform dentistry" will remain in effect until such time that I choose to terminate it.

Date: _____

Patient Name: _____

Name of Parent or Guardian: _____ Relationship to Patient: _____

Signature: _____