Children's Dental Health of Lynchburg

Specializing in Children, Teens, and Young Adults

Informed Consent to Perform General Dentistry

All PATIENTS PLEASE READ AND INITIAL SECTIONS 1-7 AND SIGN BELOW

_____**1. WORK TO BE DONE:** I authorize Summer Sawyer DMD, Shannon Sawyer DMD, or R. Drake Covey DDS and/or dental auxiliaries of their choice to perform diagnostic and preventative treatment including but not limited to examinations, radiographs (x-rays), preventative hygiene cleanings (prophylaxis), application of fluoride, and sealants. I further authorize the treatment of diseased or injured teeth and gums with dental restorations and/or removal of teeth, the replacement of missing teeth with dental prostheses, and scaling and root planning if recommended. I understand that there are risks involved in any treatment and hereby acknowledge that these risks and alternatives have been explained to me and that I will have an opportunity to ask questions regarding the risks, benefits, and alternatives of all treatment options, including no treatment.

_____**2. DRUGS AND MEDICATIONS:** I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swelling, pain, itching, and/or anaphylactic shock. I agree to the use of local anesthesia. I understand there are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. Although rare, unexpected severe complications with anesthesia can occur and include the possibility of infection, swelling, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. If needed, I agree to the use of sedative drugs to combat apprehension and/or disruptive behavior.

_____**3. CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my oral health and well being in the professional judgment of the dentist.

_____**4. RECORDS:** I authorize the use of photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, scientific publications, and consultation with other doctors.

_____**5. SUCCESS:** I understand the success of the dental treatment to be provided will require that the patient follow the post-operative and post-care instructions given by the dentist and/or the dental auxiliaries and that regular hygiene and dental visits as scheduled by my dentist and his dental auxiliaries must be maintained.

_____**6.** I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment with I have requested and authorized. I hereby authorize any of the doctors at this facility and/or dental auxiliaries to proceed with and perform the dental procedures and treatments as have been explained to me. I understand this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

_____**7.** I hereby state I have read and understand this informed consent form, and that all questions about the procedures have been 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.

Patient/Guardian Signature_____ DATE _____

Patient Name (print) _____ If guardian, relationship to patient_____

Doctor _____ Doctor Signature _____

Witness _____