General Dentistry Informed Consent

Work to be Done

I understand that I am having the following work done:
Examination _______ (Initials________________)
X-Rays ____________
Prophylaxis _______

Drugs and Medications

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

(Initials________________)

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 examination; the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials________________)

________________________________________Date __________________

Patient Signature __________________________________________

________________________________________ Witness ___________________