Permission for dental treatment, local anesthesia (numbing shots) and nitrous oxide (laughing gas)

- ✓ I hereby authorize the dentist to treat me or the person under my care (I am the legal guardian, or close relative) with the following **dental procedures** (if or when needed): prophylaxis (dental cleaning), restorations (fillings), crowns (caps), fixed bridgework (a series of joined caps), full or partial removable dentures, cosmetic dentistry, extraction (tooth removal), non-surgical and/or surgical treatment of the gums, biopsy, root canal, or any other treatment the dentist considers necessary.
- ✓ The dentist has fully explained to me the nature and purpose of the procedure(s), and has also explained the expected benefits and potential risks (from known and unknown causes) of the treatment. I have been given alternatives to the treatment, the risks and benefits of the alternatives and the consequences of having treatment withheld. I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
- ✓ I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I therefore consent to the performance of any additional treatment which the dentist considers necessary.
- ✓ I consent to the use of a **local anesthetic, antibiotics and analgesics** (pain medication) and have been explained all potential risks associated with their use. I understand that there is a slight element of risk involved with the use of local anesthesia or the use of any drug. These risks include allergic reaction, aspiration, pain, cardiac arrest, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.
- ✓ I consent to the use of **nitrous oxide analgesia**, and have been informed of the risks and benefits of its use.
- ✓ I have been given no assurances or guarantees as to outcome of the treatment. I realize that in spite of the possible complications, my proposed treatment is necessary and desired by me.
- ✓ I understand that it is vital that I give as **accurate and complete a medical and personal history** as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.
- ✓ I confirm that I have read and fully understand all of the information provided above.

Signature ____
(Patient or guardian/relative)

Print Name____
(Patient or guardian/relative)

Relationship to person above__________________________________

Signature of Dentist____

Date____

the Dental Digital Zone