Consent to Perform dentistry

1. I hereby authorize and direct the dentist(s) of **BOULEVARD DENTAL ASSOCIATES, PA** and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), photos or diagnostic aids, listed below, but not limited to:
    A. Preventative hygiene treatment, (prophylaxis) and the application of topical fluoride.
    B. Application of "sealants" to the grooves of the teeth.
    C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns), root canals or extractions.
    D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
    E. Removal (extraction) of one or more teeth and bone surgery as necessary.
    F. Treatment of diseased or injured oral tissues (hard and/or soft).
    G. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
    H. Treatment of cavities into nerve or trauma to teeth or gum infections spreading to the nerve (root canals).
    I. Implant placement and restoration.
    J. Treatment of the gums and bone around gums, either surgical or non-surgical.
2. I understand there are risks involved in any treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I understand that the success of the dental treatment to be provided will require that the patient and/or parents follow post-operative and post-care instructions of the dentist(s). I agree the success of the treatment requires all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained or I will have negative results of which this office will not be responsible or liable to.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed and agreed upon, at an additional expense. I therefore authorize and request the performance of any additional procedures that are deemed necessary and desirable to oral health and well-being, in the professional judgement of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa and nerve damage either permanent or temporary. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death.
6. I understand I will be informed of the above risks and complications prior to any procedure.
7. I agree to the use of local anesthesia and on certain cases the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure.
8. I understand and have been informed of the above risks and complications.
9. I also authorize the doctor(s) to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research scientific publications, and/or social media including but not limited to: Facebook, Instagram, Twitter, and Google.
10. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a manner satisfactory to my understanding.
11. I understand that I have the right to decline treatment and thereby hold harmless this dental office of any liability for my refusal and non-adherence to recommended treatment.
12. I further understand that this consent will remain in effect until such a time that I choose to terminate it.

Date: ______________________ Time: ____________________AM/PM File No: ________________________

Patient's Name: ____

Name of Parent or Guardian: ____

Relationship to Patient: ____

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Signature: Patient or Parent or Guardian   Witness