ROBERT L. EDWARDS, DDS, PLLC
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# Information and Consent Form

I hereby authorize Robert L. Edwards DDS, PLLC and whomever he may designate as his assistants and/or hygienists to perform upon me those dental procedures which have been discussed. I have been advised of alternate plans and options of treatment available. I consent to the treatment plan that I have accepted. If any unforeseen condition arises in the course of these procedures, I understand that additional and/or alternate procedures may be required. I further request and authorize the dentist to do what he/she deems advisable.
I am informed and fully understand that there are certain risks in any dental treatment. These risks include, but are not limited to the following: post-treatment pressure, sensitivity, temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations, tenderness of abutment teeth, soreness of tissues under removable dentures, swelling, temporomandibular (jaw) joint dysfunction, changes in occlusion(biting), sensitivity to the teeth and gums during and after cleanings, delayed healing, and treatment failure. I understand that complications may result from the use of dental instruments, drugs, sedation, anesthetic, and injections.
I understand that there are certain risks more specific to endodontic (root canal) therapy. These risks include, but are not limited to the possibility of instruments broken within the root canal, perforations of the crown or root of the tooth, damage to bridges, existing fillings, crowns, or veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which require referral to a specialist or which may make completion of treatment impossible. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease, and splits or fractures of the teeth.
I understand that there are certain risks more specific to oral surgery procedures. The most common risks include post-operative bleeding, swelling, bruising, discomfort, trismus, and loss or loosening of dental restorations. Other less common complications include, but are not limited to, infection, loss or injury to adjacent teeth or soft tissues, jaw fractures, sinus exposure, swallowing or aspiration of teeth or restorations, nerve disturbances (e.g. numbness or tingling sensation in the lip, tongue, chin, cheek, gums, or teeth), and small root fragments remaining in the jaw which may requires more extensive surgery for removal. These complications are typically transient, but in rare cases, may be permanent.
I further consent to the administration of any drugs that may be deemed advisable or necessary in my case including, but not limited to the following: anesthetics, antibiotics, analgesics, anxiolytics, and nitrous oxide sedation. I understand that prescribed medications and drugs may cause drowsiness and lack of awareness and coordination. I understand that there is an inherent risk in the administration of anesthesia which includes, but is not limited to the following: adverse drug response, allergic reactions, hematoma, increased risk of aspiration due to loss of sensation, cardiac arrest, thrombophlebitis, pain, bruising, and injury to blood vessels or nerves. Types of injections may include inferior alveolar nerve injections, nerve block injections, intraosseous injections, Gow-Gates nerve blocks, palatal injections, periodontal ligament injections, or nerve infiltrations. Complications from injections can cause itching, tingling or burning, or loss of all sensation in the lip, tongue, chin, cheek, gums, or teeth which may be temporary or in rare instances, may be permanent.
A more complete explanation of all complications is available to me upon request. I have been given the opportunity to ask questions regarding the treatment procedure, and the questions that I have asked have been answered to my satisfaction. I understand that my treatment is necessary and/or desired by me. Every reasonable effort will be made to ensure that my condition is treated properly. I have not asked for nor received a guarantee of the outcome of these procedures.

_______________________________________________ _______________
Patient/Parent/Guardian Signature Date

**Revised 3/21/2014**