Steven E. Nauss, D.D.S.

GENERAL CONSENT TO DENTAL TREATMENT

DATE: _____

I hereby consent to the performance of General Dentistry on _____ (Patient)
by Steven Nauss, D.D.S.

I further consent to treatment, as may be indicated by sound and prudent dental practices if, during the course of the treatment described above, unforeseen conditions are discovered or unusual conditions develop.

If the use of anesthesia is indicated, I consent to the administration of such anesthetics as the doctor may deem advisable and proper. I realize anesthetic risks include, but are not limited to, irritation of the veins (phlebitis) and possible serious bodily injury (i.e. Numbness to lip or gum).

I have or will have informed the doctor prior to treatment of any medical problems, abnormalities, drug allergies, or any unusual reactions to medications or anesthetics that are known to me.

The nature and purpose of the treatment to be rendered, the possible hazards involved, and alternative methods of treatment will be fully explained to me and no guarantee or warranty of the results has been made to me.

Procedure: Extraction (Removal) of Tooth/Teeth

1). Dry Socket
2). Infection
3). Decision to leave a small piece of root in the jaw when the removal would require extensive surgery and increased risk of complications
4). Bleeding and bruising
5). Swelling

Possible complications which have been explained to me;

6). Injury to adjacent teeth or fillings
7). Injury to nerves of the lower lip and tongue causing numbness which could be permanent
8). Sinus involvement which may require surgical repair
9). Pain or injury of the temporomandibular joint
10). Fracture of lower jaw

Alternative to Surgery:

I understand that if this tooth/teeth are not removed, my condition may worsen resulting in complications including, but not limited to:

1). Infection 2). Loss of additional teeth 3). Pain

I have read and understand the above. I know that I am free to ask any questions I may have about my treatment and may withdraw my consent and discontinue treatment at any time.

_____ _____

PATIENT, PARENT OR GUARDIAN **DATE**

_____ _____

DOCTOR **WITNESS**