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Informed Consent for Dental Treatment

I hereby authorize The Office of Dr. Stephen Eric Enriquez 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 or veneers (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, root canal, Dental Implants, Bone Grafting, all emergency services and any other treatment the dentist considers necessary to create better health for my mouth.

Dentistry is not an exact science and reputable practitioners cannot properly guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination but were found during the course of treatment. For example, root canal therapy may be needed during routine restorative procedures. Any change in treatment plan may result in additional fees.

Guarantees and assurances cannot be made by anyone regarding the dental treatment in which you have requested and authorized. It is essential that you keep your appointments and cooperate in your treatment to help insure you the best possible result.

The licensed provider at The Office of Dr. Stephen Eric Enriquez 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 as 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 (often known as Novocain), antibiotics and analgesics (pain medication) and have been explained all potential risks associated with their 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. Injection of a local anesthetic can at times, although rarely, cause temporary or permanent nerve damage.

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 red and dully understand all of the information provided.

By signing below, I acknowledge that I have read this statement and agree to the contents.

Signature of patient, parent, or guardian (responsible party):

Patient's Name: _____ Date:_____

Patient's Signature: _____ Date:_____

Relationship the Patient: _____ Date:_____