Absolute Quality Care Dentistry
Gray A. Bailey, D.D.S
38384 Highway 42
Prairieville, Louisiana 70769
(225)673-9535

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

Any alternatives to the recommended treatment, including no treatment, have been explained to me. In general terms the contemplated dental treatment:

All aspects of general dentistry, as needed.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and / or premedication prior to dental care being rendered. Some of these risks/complications are, but are not limited to the following:

- Infection
- Injuries to adjacent teeth and/or hard or soft tissue
- Bleeding
- Failure of wound to heal
- Dry socket
- Loss of teeth
- Incomplete removal of tooth
- Loss of bone
- Injury to adjacent structures
- Instrument breakage
- Allergic reaction to drugs
- Bacterial endocarditis
- Tooth or fragment in maxillary sinus
- Breakage of root(s)
- Death (in rare instances)
- Retained root fragments
- Swallowing and/or aspiration of objects
- Failure of treatment to accomplish its purpose
- Trismus (jaw pain or difficulty opening mouth)
- Paresthesia or numbness of tongue, and/or mouth, and/or face
- Fracture of mandible (lower jaw) or maxilla (upper jaw)
- Slough (unanticipated loss of hard and/or soft tissue)
- Opening between mouth and sinus or mouth and nose

Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s).

Acknowledgement

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given adequate opportunity to ask questions and all questions that were asked were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid unless revoked by me in writ

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Date Signature of Patient or Guardian