Informed Consent for General Dental Procedures

Patient's Name:_____ Birth date:_____

I give consent for myself/ my child to receive dental treatment deemed necessary by the providers at Dr. Robert Kelly DDS office. These procedures include, but are not limited to, examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, radiographs, photographs of the head and neck areas, including the profile, face, teeth, smile, and intraoral features, restorations (composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, implant surgery , implant restoration and local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendation regarding medication, pre and post treatment instructions, referrals to other dentists or specialists and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances for a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition advise your dentist immediately so he/she can consult with your physician if necessary.

This consent shall be considered in effect until rescinded or revoked.

_____ _____ _____

(Sign your name) (Relationship) (Date)