CONSENT FOR DENTAL TREATMENT

I authorize Dr. Almeida and/or Dr. Bell to take x-rays, study models, photographs, and/or any other diagnostic aids deemed appropriate by Dr. Almeida and/or Dr. Bell to make a thorough diagnosis of my dental needs. I also authorize Dr. Almeida and Dr. Bell to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that dental treatment and the use of dental anesthetics embodies a certain risk. These risks include, but are not limited to:

1. Postoperative discomfort that may require several days of home care.
2. Injury or damage to adjacent teeth or restorations.
3. Postoperative infection that may require additional treatment.
4. Stretching of the corners of the mouth that may cause cracking, bruising, and may heal slowly.
5. Allergic reactions (previously unknown) to any of the medications used during the course of treatment.
6. In some cases, after treatment, the possibility of nerve damage may require root canal therapy.
7. Although rare, dental treatment including injections can cause prolonged numbness. Typically it is a temporary condition, but can be permanent.

I also understand that I may ask any questions regarding my care including a detailed explanation of the risks versus the benefits of the proposed treatment.

_____ _____

Patient/ Legal Guardian Signature Date

_____ _____

Doctor's Signature Date