Lowell Tooth Docs
59 Lowes Way
Suite 202
Lowell MA 01851

(978)454-8400

www.lowelltoothdocs.com

info@lowelltoothdocs.com

Informed Consent for General Dental Procedures

Patient Name:* _____ (Last) * _____ (First) _____ (MI) _____ (Preferred Name)

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions have been answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

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 recommendations 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 of a poor outcome.

Please read the items listed below and sign at the bottom of the form.

Treatment to be provided:

I understand that during the course of my treatment that the following care may be provided:
Examinations * Diagnostic Services * Preventative Services * Restorations * Local Anesthesia * Periodontal Services * Other

Drugs and Medications:

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). It is my responsibility to report any of these occurrences and immediately and report to the nearest emergency room for further evaluation.

Changes in Treatment Plan:

I understand that during the treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

No Implied Guarantee:

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I acknowledge that no guarantee or