



Isaac A. House, DDS A Professional Corporation
4700 Highway 80, Haughton, LA 71037

Consent for dental treatment and acknowledgment of information

State law requires us to obtain your written consent for dental extractions. What you are being asked to sign is confirmation that we have discussed the nature and purpose of the contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

I understand that dentistry is not an exact science and that complications may occur despite the best efforts of the doctors, staff, and myself/person of whom I am a legal guardian. A partial listing of the risks known to be associated with dental extractions and with the associated anesthetic are:

- TMJ Dysfunction, or worsening of TMJ condition including trismus (jaw pain or difficulty opening mouth), or change in the bite
-Dry socket and failure of the wound to heal, including the possibility of an opening between mouth and sinus or mouth and nose
-Breakage of teeth root(s)/retained root fragment(s) including tooth or fragment in the maxillary sinus if an upper tooth
-Paresthesia (permanent or temporary numbness of the cheeks, gums, teeth, lips, tongue, chin and/or face)
-Further surgery or treatment that may require referral to a specialist if complications develop
-Loss/injuries to adjacent teeth, bone, and soft tissues and incomplete removal of the tooth
-Severe swelling/bruising or bleeding which may be heavy enough to stop the procedure
-Motor and sensory nerve damage (function and feeling), salivary gland duct change
-Failure of the treatment to accomplish its purpose or restore appearance
-Stretching of the mouth which may result in cracking or bruising
-Fracture/breakage of the jaw or sinus
-Salivary gland duct change
-Drug/allergic reaction
-Infection and/or pain
-Loss of taste

State law also requires that I specifically advise you that, although rarely occurring, the dental treatment or anesthetic may result in:

- Loss of organ(s) or loss of function of an organ
-Loss of function of the face, arm(s) or leg(s)
-Permanent or disfiguring scarring.
-Paraplegia or quadriplegia
-Brain damage or death

Acknowledgement

I acknowledge that I have read and I understand the information on this page (or that it has been read to me). I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have had an opportunity to ask questions about the proposed treatment or procedure. All of the questions about the proposed treatment(s) or procedure(s) that I have asked have been answered in a satisfactory manner. I understand that the success of this treatment and the avoidance of treatment complications depends to an extent upon my complying with the instructions given to me and my keeping the appointments for treatment or follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complications. Further treatment which is not currently anticipated may be discussed, or administered at a later date. This consent will remain valid until revoked by me in writing. I waive any further disclosures or information.

I hereby authorize and direct Dr. Ike A. House and/or his associates, hygienist, assistants of his choice to perform upon me or the person of whom I am a guardian, diagnostic, surgical or dental procedures including any necessary or advisable anesthesia, radiological services, and the disposal of any tissue removed, and I hereby consent thereto.

Date _____ Signature of patient or guardian (if a minor) _____

I hereby certify that I have provided and explained the information set forth herein and answered all questions of the patient, or the patient's representative, concerning the dental treatment or surgical procedure, to the best of my ability.

Date _____ Signature of dentist _____