



David T. Rothan, DDS, General Dentist • Michael J. Rothan, DDS, General Dentist

CONSENT FORM

Patient:
Date of Birth:

I hereby authorize Dr. Rothan and whomever he/she may designate as his/her assistants or hygienists to perform upon my child or me the following procedures: Examinations, cleanings, fillings, preventive dentistry, root canal treatment, x-rays, extractions and other dental services which may be listed separately.

I request and authorize him to do whatever he deems advisable in any condition arises in the course of these designated operation and/or procedures calling, in his judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages, and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment after having been advised of the alternate plans of treatment available and the known material risks, advantages, and disadvantages of the alternative treatment.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, understood that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves that may be caused by injections of any medications or drugs.

I am informed and fully understand that in any type of surgery there are certain unavoidable complications. In oral; surgery, the most common of these complications includes post-operative bleeding, swelling, or bruising, discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete medical and personal history as possible including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient's Signature (Parent or Guardian) _____ Date _____

Dentist's Signature _____ Date _____

Witness's Signature _____ Date _____