cedar place dental
FAMILY AND COSMETIC DENTISTRY

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General Consent for Treatment and Local Anesthesia

You have a right to be informed about your diagnosis and planned treatment so that you may make a decision whether to undergo a procedure after knowing the risks and hazards. This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so you may give your informed consent to the procedure. The following risks and or complications exist with dental treatments.

Complications: resulting from the use of dental injections and anesthetics include and are not limited to:

- Swelling, bleeding, infection, or discomfort at site of injection
- Prolonged numbness and tingling sensation in oral cavity. These sensations are usually temporary, but can be permanent
- Jaw muscle cramps and spasms; Jaw joint difficulty or pain radiating to head, neck and ear
- Nausea and vomiting
- Allergic reaction
- Rapid or irregular heartbeat
- Biting of the cheek, lip and tongue after treatment resulting in swelling and discomfort

Complications: from medications or prescription medication given in the office are common. To decrease your risk of a potentially serious drug reaction, please provide us with the knowledge of any past drug allergies or adverse reactions. In addition, we are careful about the medications we prescribe and will not prescribe a medication unless it is absolutely necessary:

- Allergic reaction- itching, swelling, difficulty breathing
- Adverse reactions- nausea, vomiting, headache, drowsiness

Depending on the procedure, minor to moderate sensitivity of the teeth or soreness of the gums in the area that was treated is completely normal. If you have any questions or concerns after care, please do not hesitate to call our office.

I have read and understand this form, and hereby authorize Dr. Nickie L. Perry, DDS, PA, Dr. Julianna K. Ervin, DDS, and licensed team members to administer anesthetic from this day forward. I understand the doctor may discover other or different conditions that may require additional or different procedures than those planned. I authorize them to perform such other procedures as they deem necessary in their professional judgment in order to complete my treatment.

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Printed Name of Patient

____ ________________________________
Signature of Patient or Legal Guardian Date

____ ________________________________
Witness Date