Taylor Family Dental
+1 (303) 838-0311 info@taylorfamilydental.com

General Informed Consent

Consent for Dental Examination and Treatment

I, {Patient: First Name} {Patient: Last Name}, hereby authorize the dental professionals at Taylor Family Dental to perform a comprehensive dental examination, including but not limited to diagnostic procedures such as X-rays, photographs, and other necessary evaluations.
I understand that based on the findings, a diagnosis and treatment plan will be discussed with me. I voluntarily consent to receive dental treatment deemed necessary or advisable, including preventive, restorative, and/or emergency procedures.

Consent for Local Anesthesia and Medications

I consent to the use of local anesthesia and any medications as deemed necessary for my treatment. I understand the risks associated with anesthesia, including but not limited to temporary or prolonged numbness, allergic reactions, or other complications.

Acknowledgment of Risks and Benefits

I understand that dental procedures, like all healthcare treatments, carry some risks and potential complications. These may include, but are not limited to:

- Pain or discomfort
- Swelling or infection
- Tooth sensitivity
- Reactions to medications or anesthesia
- Unexpected outcomes requiring additional treatment

I understand that no guarantees or assurances have been made regarding the results of treatment.

Patient/Guardian Signature:

_____

Date: _____