253 DENTAL CARE

Dentistry Dedicated to Excellence

STATEMENT OF CONSENT FOR DENTAL PROCEDURES

1. I hereby authorize Mark V. Walker DDS PLLC and/or other dentists or assistants as may be selected by him to treat my conditions. The procedures necessary to treat the conditions have been explained to me and I understand the nature of the procedures recommended in my wellness plan.

2. I have been informed of my current dental diagnosis and of possible alternative methods of treatment (if any).

3. I further understand that this is an elective procedure and that other forms of treatment or no treatment at all are choices that I have, and I have discussed the known risks of these other forms of treatment with my dentist.

4. The doctor has explained to me that there are certain inherent and potential risks in ANY treatment plan or procedure. We do not expect these to occur, but there is that possibility. Such risks include, but are not limited to, the following:
A. Nerve inflammation leading to hot and cold sensitivity
B. The need for endodontic therapy (root canal treatment)
C. Cracked cusps
D. A shorter length of serviceability of the restoration with the need for more frequent replacement
E. In cases where the previous restorations (fillings) are very large, the use of cast or full coverage crowns, or bonded porcelain are suggested to prevent fracture of the tooth.

5. It has been explained to me that, during the course of the procedures, unforeseen conditions may be revealed that necessitate an extension of the original procedures or different procedures than those set forth in the wellness plan. I, therefore, authorize and request that the persons described in paragraph 1 above perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph 5 shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

6. I consent to the administration of local anesthesia, nitrous oxide, and/or oral anxiolysis/sedation in connection with the procedures listed in my wellness plan, by any of the persons described in paragraph 1, and to the use of such

anesthetics or other medications as may be advisable. I recognize that there are always risks to life and health associated with anesthesia and such risks have been explained to me.

Injections of local anesthetics can cause paresthesia (numbness) of teeth, lips, tongue and surrounding tissues. Though quite rare, this numbness can sometimes be permanent.

7. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device until I have recovered from the effects of the anesthetic medication and drugs that I may have been given in the office for my care.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

8. I understand that dentistry is not an exact science. It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

9. The patient is an important part of the treatment team. It is very important that you provide your dentist with accurate information before, during and after treatment. This includes a complete medical and allergy history and medications taken, as well as any changes to your medical history that might occur. Many health conditions and medications and/or supplements impact your dental care and it is important for the dentist to be aware of all medical conditions, medications, and allergies to safely provide dental treatment to you. 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 specialist, and return for scheduled appointments.

I agree to cooperate completely with the recommendations of the doctor while I am under his care, realizing any lack of same could result in a less than optimum result and that failure to follow the doctor’s suggestions and directions could be even life threatening.

10. I have been given ample opportunity to ask questions and any questions I have asked have been answered in a satisfying manner.

11. I certify that I read and write English and fully understand this consent. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT.

_____ _____

Patient Date

_____ _____

Dentist Date