REQUEST AND CONSENT TO DENTAL TREATMENT

1. I request and authorize Dr. Robert Nyberg and/or assistants/hygienists of his choice, to perform the following treatment/procedure(s) for:

Patient Name:_____

Description of treatment/Procedure(s): Routine fillings, cleaning, extractions, crowns, bridges, dentures and other dental services as needed.

2. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by the doctor responsible for my/the patient's treatment.

3. I have had explained to me, and I have had sufficient opportunity to discuss my/the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment, compared with alternative approaches and/or no treatment.

4. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during and following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a transient or permanent temporomandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

5. I understand that during the course of my/the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those planned. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made concerning the results of the treatment that I/the patient will receive.

6. WOMEN ONLY: If on birth control pills, it is IMPORTANT TO UNDERSTAND that ANTIBIOTICS have been reported to decrease oral contraceptive effectiveness, resulting in a CHANCE OF UNPLANNED PREGNANCY. If antibiotics are prescribed, other contraceptive methods are recommended if pregnancy must be avoided.

7. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for me/ the patient.

8. I understant that I may revoke this consent to treatment at anytime and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

9. I confirm that I have read this form, or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed below.

SIGNATURE OF PERSON CONSENTING TO TREATMENT:

_____ DATE _____

Dentist Signatue:_____DATE _____

Witness Signature: _____DATE _____