Eric Andersen, DDS
400 North Allen Drive #101
Allen, Texas 75013

TREATMENT CONSENT FORM

Patient's Name: _____Date of Birth: _____

I hereby authorize Eric P. Andersen, DDS and whomever he may designate as his assistants/hygienists to perform upon me the following procedure(s): _____

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the recommended treatment and alternative treatment, if any and the consequences of not having the treatment performed.

I request and authorize Dr. Andersen to do whatever he deems advisable if any unforeseen condition arises in the course of the designated treatment calling for, in his judgment, procedures in addition to or different from the recommended treatment.

I further consent to the administration of local anesthetic, antibiotics, analgesics or any other therapeutic drugs that may be deemed necessary in my case and I understand there is a slight element of risk inherent in the administration of any drug or anesthetic agent. The risk involved may include adverse drug responses, allergic reactions, cardiac arrest, aspiration, thrombophlebitis (irritation and swelling of a vein), pain, discoloration and injury to blood vessels or nerves which can be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of procedures are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling, bruising, discomfort, stiffness of the jaws, loss or loosening of dental restorations. Other complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbance including numbness of the mouth and lip tissues, jaw fractures, sinus exposure, swallowing or aspiration of teeth and/or restorations and small root and tooth fragments which may remain in the jaw which could require future surgery for removal.

I realize that my contemplated procedure is necessary and desired by me and should proceed in spite of possible complications and risks. 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 procedure.

I have provided an accurate and complete medical and personal history including antibiotics, drugs, medications and foods to which I am allergic or have had adverse reactions to in the past. I will follow any and all instructions as explained and directed to me and will permit prescribed diagnostic procedures as indicated.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical and dental condition, contemplated and alternative treatment and procedures, if any and the risks and potential complications and alternative treatments and procedures prior to signing this consent.

Patient or Guardian Signature Date

Eric P. Andersen, DDS

Eric P. Andersen, DDS Date

Witness Signature Date