KENT ISLAND DENTISTRY
1231 Shopping Center Road
Stevensville, MD 21666

CONSENT FOR TREATMENT

Patient's Name_____.

Acknowledgement

I have provided as accurate and complete a medical and personal history as possible including: antibiotics, drugs, or other medications, including vitamins and herbal supplements, that I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

I realize that in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science, but the dentists at Kent Island Dentistry will do everything possible to optimize your dental care.

Risks of the Recommended Treatment

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications can occur. These include: tooth sensitivity after certain procedures, post-operative discomfort after Root Canal Therapy, extractions, or restorative dentistry (fillings,crowns), temporary or permanent paresthesia (numbness) secondary to anesthetic injections, extractions or implant placements, and file breakage during Root Canal Therapy.

Please ask your dentist questions about these risks and other risks you have heard or thought about.

Signed:_____Date:_____
Patient or Guardian