DENTAL ARTS of CORINTH, PLLC

Informed Consent to Perform Dentistry

I hereby authorize and direct the dentists of Dental Arts of Corinth, PLLC to perform the following dental and/or orthodontal treatments, oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, and/or diagnostic aids. These treatments and/or procedures include, but are not limited to examinations, oral prophylaxes (cleanings), fluoride applications, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) procedures, and extractions.

I understand that there are risks involved in these treatments and hereby acknowledge that the risks have been explained to me, that I have had an opportunity to ask questions regarding the treatments and their risks, and that I fully understand those risks.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia, depending on the judgement of the doctors.

My treatment options have been explained to me. Alternate methods of treatment, if any, have been explained to me, as have the advantages, disadvantages, and risks of each. I am advised that though positive results are expected, the possibility and nature of complications cannot be accurately anticipated.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performance of any additional procedures that are deemed necessary or desirable.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation and medications. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma, (swelling or bleeding at or near the injection site), fainting, lip and cheek biting, resulting in ulceration and infection of the mucosa.

_____	_____	_____
Patient/Guardian Signature:	Date:	Relationship to Patient:

Phone: (662) 287 - 3156
Fax: (662) 287 - 3157
1025 Foote Street Corinth, MS 38834