GENERAL DENTISTRY AUTHORIZATION FORM

PATIENTS NAME: _____ DOB: _____
Last Name

I hereby authorize and request treating Dentist at OLE HEALTH to perform general dentistry such as exam, x-rays, prophy (cleaning), administration of local anesthetic, composite and amalgam fillings, and those related procedures necessary and/or incidental to the above listed procedure as determined in the dentist's discretion. I have also been told that administration of local anesthetic might cause allergic response, temporary or permanent injury to nerves, and/or blood vessels from the injection.
It has been explained to me, and I understand, that alternatives to these procedures include no treatment.
It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted and furthermore, that the above procedure may involve the possibility of complications which have been explained to me, including but not limited to:

A. Injury to adjacent teeth and fillings.
B. Stretching at corners of the mouth with resultant cracking and bruising.
C. Exposure of the pulp (nerve) of the tooth. This would require alternate treatments.
D. Subsequent abscess or infection due to trauma of placing filling.

I hereby acknowledge (1) That I have read and understood the information provided in this form, (2) That the procedure set forth above has been adequately explained to me by the Dentist, (3) That the risks, the expected benefits and/or complications of such procedure, as well as any alternative methods of treatment and their risks and benefits have been explained by the Dentist, (4) That I have had the chance to ask questions, (5) That I have received all the information I desire concerning the procedure, and (6) That I authorized and consent to the performance of the procedure.

SIGNATURE: _____ DATE: _____
(Self/Parent/Conservator/Guardian)

IF SIGNED BY OTHER THAN PATIENT/PARENT/GUARDIAN,

INDICATE RELATIONSHIP: _____