General Consent to Perform Dentistry

1. I hereby authorize and direct Gary A. Cooper, D.D.S. and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedures), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
   A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
   B. Application of sealants to the grooves of teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
   D. Replacement of missing teeth with dental prostheses (bridges, partial and full dentures).
   E. Removal (extraction) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and/or soft).
   G. Use of sedative drugs to control apprehension.
   H. Treatment of Mal-positioned teeth and/or oral developmental abnormalities.
2. I understand that treatment will be discussed with me before it is performed. The risk of not doing treatment along with the risk of the treatment itself will be explained to me. I understand that I will have the opportunity to ask questions regarding the treatment and the risks.
3. I recognize that during treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. 1 therefore authorize and request the performance of any additional procedures that are deemed necessary and desirable to oral health in the professional judgment of the dentist and/or auxiliary.
4. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling or bleeding at or near the injection site, pain, bruising, allergic reactions, heart racing, fainting, and cheek biting resulting in ulceration I also understand that there are rare potential risks such as unfavorable reactions to medications resulting in respiratory and/or cardiovascular collapse that could result in coma or death. I understand and have been informed of the above risks and complications.
5. Success of the dental treatment to be provided will require that the patient follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
6. I authorize the dentist to use photographs, radiographs, oilier diagnostic materials and treatment records for the purposes of leaching, research and scientific publications.
7. I hereby state that I have rear! and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment. I further understand that this consent will remain in effect until such time that 1 choose to terminate it.

Date _____

Patient's Name _____

Signature of Patient (Parent or Guardian if under 18 yrs old.) _____

Witness (from dental office) _____