CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law required us to obtain your consent for the contemplated dental treatment. This is a confirmation that we have discussed the nature and purpose of treatment, the alternatives to the recommended treatment (including no treatment) and the advantages and disadvantages of each, and the risks associated with treatment. We will explain any portion of the treatment or forms that you do no understand.

I hereby authorize and direct Anthony B. Rainwater, DDS and/or assistants to perform upon me the following diagnostic, surgical or dental procedures: including any necessary or advisable anesthesia.

RISKS ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT

I understand that dentistry is NOT an exact science and that complications may occur despite our best efforts. A partial listing of the risks know to be associated with this treatment and with the associated anesthetic is:

- Swelling and Bruising
- Retained Instrument Fragments
- Stretching of the Mouth (which may bruise the muscles)
- Paresthesia (permanent or transient numbness)
- Sinus Involvement
- Failure of the Treatment to Accomplish its Purpose
- Drug/Allergic Reactions
- TMJ Dysfunction
- Pain
- Infection
- Change in the Bite
- Trismus

ACKNOWLEDGMENT

I acknowledge that ***I have read and I understand the information on this page*** of the consent form (or that it has been read to me). I understand the information contained in it, including all of the technical terms, which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about the treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand that the success of the treatment and the avoidance of treatment complications depend to an extent upon my complying with the treatment follow-up which has been explained to me, my following the instructions given to me and my keeping the appointments for the treatment or follow-up office visits scheduled or recommended. I also unerstand that I am to notify the Endodonist immediately of any suspected complications, where further treatment may be discussed or administered which is not currently anticipated.

This consent form will remain valid until revoked by me in writing.

Date____________________ Signature of Patient ____

Signature of Guardian___________________________ Signature of Witness _____________________

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