CALEDONIA
FAMILY DENTISTRY

CONSENT TO GENERAL DENTAL TREATMENT

1. I request and authorize Caledonia Family Dentistry, and/or such other persons as he/she may appoint, to perform or assist in the performance of the dental treatment or procedures indicated below, which consists of but is not limited to: general dental treatment, including hygiene treatment. I understand that the purpose of this procedure(s) is treatment purpose.

   I understand that there have been no guarantees given or implied of any sort by anyone as to the results that may be obtained.

2. I understand that the above described treatment or procedure involves the following risks: nerve damage, bleeding, swelling, infection, pain.

3. As an alternative to this therapy, I may elect to deny treatment. I also understand that failure to treat conditions will result in non-treated outcome.

5. Further, it is understood that unforeseen conditions or circumstances may arise during the course of the above described procedure or alternate treatment. Therefore, I consent to and authorize the performance of any care, procedure, or treatment not specified above that the dentist believes necessary or advisable as a result of these unforeseen events or conditions.

6. I consent to the administration of any anesthetic that the dentist (or appointees) deems necessary to provide proper treatment.

7. I understand that there are risks involved with the administration of anesthesia.

8. I have been given an opportunity to refuse to consent to any and all treatment or procedures specified in the this form and have indicated my exclusions by drawing a line through the objectionable word(s), sentence(s), or paragraph(s), and writing my initials next to the portion to which I refuse to consent. I am also free to indicate at the end of this form anything not mentioned herein, but to which I refuse to consent.

I certify that I have read and understand the above. I accept all risk of, if any, in hope of obtaining the desired beneficial results. I acknowledge that the dentist has explained all of the above to me in a manner to allow me to comprehend the consequences of my actions. Any questions about this treatment plan and its attendant risks have been answered fully and to my complete satisfaction.

_____	_____	_____
Signature Patient or Guardian	Print	Date
_____	_____	_____
Witness	Print	Date

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S DENTAL RECORD

3352 Brown Rd. Caledonia, NY 14423
585.538.4500

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TREATMENT CONSENT FOR A MINOR

We are required to obtain parental consent for any dental treatment of a minor (any child under the age of 18). In the case of young adults who remain on the same account as their parent(s) or guardian, parental consent is also recommended.

Patient's Name:_____

In general terms the dental treatment may or may not include some of the following:

- Radiographs (x-rays) of teeth and jaw bones
- Cleaning and fluoride treatment
- Sealants
- Fillings (composite or amalgam)
- Extractions (additional consent must be signed by the parent or guardian)

Some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride, and children biting and injuring the tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, and allergic reaction.

I certify that I have read and understand the above. I hereby authorize Caledonia Family Dentistry's Dentists and/or dental auxiliaries to perform dental treatment on my child.

_____ _____ _____
Signature Parent or Guardian Print Date

_____
Relationship to Patient

_____ _____ _____
Witness Print Date

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S DENTAL RECORD

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