Informed Consent for Dental Treatment

Patient Name:_____

I hereby authorize Mark E. Lawton and his licensed providers to treat me or the or the person under my care (I am the legal guardian, or close relative) with the following dental (if or when needed) : prophylaxis (dental cleaning), restorations (fillings), crowns, fixed bridgework, full or partial removable dentures, cosmetic dentistry, extractions, non-surgical and/or surgical treatment of gums, root canals, dental implants, bone grafting, all emergency services and any other treatment the dentist considers necessary to create better health for my mouth.

Dentistry is not an exact science and reputable practitioner cannot properly guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination, but were found during the course of treatment. For example, root canal treatment may be needed during routine restorative procedures. Any change in treatment plan may result in additional fees.

Guarantee and assurances cannot be made by anyone regarding the dental treatment which you have requested and authorized. It is essential that you keep your appointments and cooperate in your treatment to help insure the best possible results.

The licensed provider at Mark E. Lawton's has fully explained to me the nature and purpose of the procedure(s), and has also explained the expected benefits and potential risks(from known to unknown causes) of the treatment. I have been given alternatives to the treatment, the
risks and benefits of the alternatives and the consequences of having treatment withheld. I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactory.
I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I therefore consent to the performance of any additional treatment which the dentist considers necessary.

I consent to the use of local anesthetic, antibiotics and pain medication, which have been explained of all potential risks associated with their use. I understand that there is a slight element of risk involved with the use of local anesthesia or the use of any drug. These risks may include allergic reaction, aspirations, pain, cardiac arrest, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drug. Injection of a local anesthetic can at times although rarely, cause temporary or permanent nerve damage.

Signature_____

Date:_____