General Consent Form

Dr. Roger Mueller and his team are up to date on all the most of the state of the art techniques in dentistry. It is important to us that you are always receiving the best care possible. And before beginning any treatment we take in to consideration all of your individual health concerns; and possible side effects of any treatment recommended to you. Although it is important that you understand when beginning treatment that dentistry is not an exact science and that no specific results can be assured or guaranteed.

I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated fees are my financial responsibility.

I understand **any time a tooth is prepared, for any reason**; there is always irritation to the nerve of the tooth, which may result in post-operative sensitivity or, in some cases, permanent nerve damage requiring root canal treatment or removal of the tooth. It is difficult to predict how your tooth may respond to treatment. I understand that any associated fees are my financial responsibility.

I have given a complete and truthful medical history including all medicines, drugs use, pregnancy, etc.

I understand that antibiotics, analgesics (pain medication), anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, bruising, itching, pain, nausea. I have been told that antibiotics can interfere with the effectiveness of birth control pills. I understand that dental anesthesia(injections) are considered safe but have some **rare** possible side effects such as Hematoma(swelling and or bruising of gum tissue), Paresthesia(temporary paralysis or numbness in your mouth or face), rapid heart rate or trouble breathing, sweating, double vision. I understand that pain medications are meant to dull the pain and take the edge off and may not be effective for pain elimination.

My signature signifies that I understand the information above and have no further questions regarding this information.

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Patient's (or Legal Guardian's) Signature Date