Broadmoor Valley Dental Care

OLIVER M. SPAETH, DDS

Patient-centered dentistry for healthy, beautiful smiles

General Consent Form

Patient Name: _____ Date: _____

Account #: _____

I hereby authorize my dentist, **Dr. Spaeth** and whomever he/she may designate and his/her associate, assistants, and/or hygienists, to perform upon me/my child those dental procedures which we have discussed, and I have accepted in the treatment plan If any unforseen condition arises in the course of the designated procedures requiring, in their judgement, procedures in addition to or different from those now contemplated, and after appropriate discussion, I further request and authorize whatever he/she deems advisable. I consent to the treatment plan I accepted after having been advised on any alternative treatment available.

I have been informed and fully understand that there are certain risks in any treatment. These risks include but are not limited to:

- Post treatment pressure, temperature sensitivity, pulpal inflammation, pain or throbbing.
- Fracturing of new restorations due to early biting pressures
- Tenderness of tissues under removable appliances
- Post surgical pain, throbbing, swelling, bleeding, re-infection, and root fracture during surgery.
- Sensitivity of teeth and/or tissues after routine prophylaxis and scaling and root planning.
- TMD- jaw pain or tenderness of jaw joint.
- Nerve disturbances (e.g. numbness in mouth and lip tissues). These complications may be temporary or permanent.

I further consent to the administration of any durgs that may be deemed necessary in my/my child's case, including, but not limited to:

- Local anesthetics, antibiotics, and analgesics

I understand that there is an element of risk inherent in the administration of any drug or anesthetic. This risk includes, but is not limited to the following complications:

- Adverse drug reaction (e.g. allergic reaction), cardiac arrest, thrombophlebitis (e.g. irritation and swelling of a vein), aspiration, pain, discoloration and injury to blood vessels and nerves which may be caused by injection of medications, drugs, or anesthetics.

I have been given the opportunity to discuss these complications and a more complete explanation is available to me upon request from the Doctor.

I am aware that, even though there are these complications and risks, my/my child's treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Date	Patient/Parent/Guardian Signature	Witness

Email Form

Please email this form with our email button or save the file and email to info@bvdc.net.