



Consent to Proceed

I authorize Brookside Dental and/or such assistance as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or surgical treatments.

I understand that the administration of local anesthetic may cause an unpleasant reaction or side effects, which may include, but are not, limited to bruising; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after complications of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissue may also be sensitive or painful and/or after treatment. Although rare, it is possible for the tongue, cheek, and or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I do understand that as part of dental treatment items including but not limited to crowns, small instruments, drill components, etc may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks of substantial and serious harm, if any which may be associated with general preventative and operative procedures in hopes of obtaining the potential desired results, which may not be achieved for the benefit of my minor child or ward. I acknowledge the nature and purpose of the forgoing procedures have been explained to me and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ **Date:** _____

(Patient, legal guardian, or authorized agent of patient)

Witness _____ **Date:** _____