MILES & MICHAEL DENTISTRY

Sandra L. Miles D.D.S. P.A. Jaimee A. Michael D.D.S.

Web www.milesandmichaeldentistry.com

Email smilesdds@bizec.rr.com
smiles2@officedds.com

2802 Market Street
Wilmington, NC 28403
(910) 815-0811
Fax (910) 815-0665

General Consent for Treatment

It is very important to provide accurate health information, to follow the doctors' recommendations regarding medications, pre- and post-treatment instructions, and referrals, and to return for scheduled appointments. Failure to do so may result in a poor outcome, and noncompliant patients may be dismissed from the practice. Please read and sign below the following statements.

1. **RADIOGRAPHS, EXAMINATION, AND TREATMENT** I understand that my initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan, and that treatment could include preventative, periodontal, restorative, endodontic, and/or surgical care. I also understand that periodic radiographs are required, my treatment plan may change as needed, I have the right to accept or reject recommended dental treatment after discussion and consideration of the potential benefits, risks, and complications of all treatment options, and I may have all of my questions answered.

2. **MEDICATIONS** I understand that I may receive local anesthetic and/or other medication(s) that may require a designated driver and/or, in rare instances, result in an adverse reaction and additional medical attention. I also understand that failure to take medications as prescribed may lead to continued or worsening of my condition, and that antibiotics can reduce the effectiveness of oral contraceptives.

3. **TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTIONS** I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the jaw joint following routine dental treatment during which the mouth is held open. These symptoms are usually temporary and well tolerated by most patients, however I understand that the cost of any treatment that may be needed is my responsibility.

4. **GENERAL RISKS** I understand that dental work comes with risks, including (but not limited to) complications resulting from the use of instruments and medications, such as pain, injury, inflammation, infection, bruising, swelling, bleeding, sensitivity, numbness/tingling sensations, changes in bite (biting), muscle cramps/spasms, temporomandibular jaw joint (TMJ) difficulty, loosening/loss of teeth and/or restorations, nausea, allergic reactions, delayed healing, sinus complications, and further treatment.

I understand that dentistry is not an exact science and results cannot be guaranteed. I also understand that each dentist is individually responsible for their provided dental care, and not that of any other dentist. I had sufficient time to read this document, understand the above statements, and all of my questions have been answered. By signing, I acknowledge and accept these statements and agree to proceed.

_____ _____

Patient Name (Print) **Date of Birth**

_____ _____

Patient or Legal Representative Signature / Relationship (if applicable) **Date**