# ADULT CONSENT TO PERFORM DENTISTRY

| Patient's Name: | Date of Birth: | MRN: |
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I hereby authorize and direct Elica Health Centers (EHC) dentists and dental auxiliaries of their choice, to perform the following dental treatments:

- The use of any necessary radiographs (x-rays), or diagnostic aids for dental examination.
- Cleaning of teeth, topical fluoride treatment, dental restorations, dental prosthesis, oral surgery procedure(s), treatment of hard and/or soft tissues, and specialty referrals.

I understand that there are risks involved in these treatments. The risks, treatment, alternate treatment methods, if any, and advantages and disadvantages have been explained to me. I had the opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

I agree with the use of local anesthesia. I understand and have been informed that there are possible risks and complications associated with administering local anesthesia. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping or breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

I understand that though good results are expected, the possibility of complications cannot be accurately anticipated and there can be no guarantee either expressed or implied as to the results of the treatment or as to the cure. During treatment, unforeseen circumstances may involve additional or different procedures from those discussed. I authorize and request the performance of any additional procedures that are deemed necessary or desirable to my oral health and well-being in the professional judgment of the dentists of EHC.

I acknowledge that I have received from Elica Health Centers a copy of the **Dental Material Fact Sheet.**

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND ALL MY QUESTIONS WERE ANSWERED.**

Patient / Legal Guardian's Signature: _____ Date: _____

Provider / Dentist's Signature: _____ Date: _____

Witness / Translator's Signature: _____ Date: _____