"Healing with Heart"
Elica Health Centers

Adult Consent to Perform Dentistry

I hereby authorize and direct the dentists of Elica Health Centers and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

- Cleaning of teeth and the application of topical fluoride.
- Treatment of diseased or injured teeth with dental restorations (fillings).
- Replacement of missing teeth with dental prosthesis.
- Removal (extraction) of one or more teeth.
- Treatment of diseased or injured oral tissue (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
- Postponing or delaying treatment at this time.

I understand that there are risks involved in this treatment and hereby acknowledge that these risks have been explained to me, that I have had an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages and risks of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee either expressed or implied, as to the results of the treatment or as to the cure.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my oral health and wellbeing in the professional judgement of the dentists of EHC.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these being 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 acknowledge that I have received from Elica Health Centers a copy of the **Dental Material Fact Sheet.**

Patient Signature: _____Date: _____

Provider/Dentist Signature: _____ Date: _____

Witness/Translator Signature: _____ Date: _____