Laurie A. Rosato, DMD, PLLC

GENERAL CONSENT TO PERFORM DENTISTRY

Patient Name:_____ Date of Birth:_____

I hereby authorize Dr. Laurie Rosato, DMD, and whomever she may designate as her assistants, to perform upon my procedures and operations in the realm of General Dentistry.

I consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g. allergic reactions), cardiac arrest, aspiration and thrombophlebitis (e.g., irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs. In addition, I understand that there are certain inherent and potential risks to the administration of local anesthetic such as infection associated with needle trackage, injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side: this may persist for several weeks, months or in remote instances permanently.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss of loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing of aspiration of teeth and restorations, and small root fragments remaining in the jaw which may require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided an accurate and complete medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures. I understand it is my responsibility to keep the office of Laurie A. Rosato, DMD abreast of any changes in my health history and medications.

I have had the opportunity to ask questions and received answers and explanations for all questions about my medical condition, contemplated and alternative treatment and procedures, risks and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient or Legal Guardian Signature_____Date_____

Dentist Signature_____Date_____

Witness's Signature_____Date_____