RICHARDS DENTAL CARE

Pete Richards, DDS, PA, MAGD

General Consent

I give Dr. Pete Richards and his staff permission to take radiographs, images, photos and any other diagnostic date which will better allow the Practice to diagnose and plan for the treatment of my mouth. This further gives the Practice permission to provide me with preventive care (cleanings, etc.) and other non-invasive or non-reversible procedures. I understand that I may be asked to sign additional consents as specific dental conditions are identified and proposed to me for treatment.

Any invasive or irreversible dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an extraction site (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue or other areas
- Bruising, swelling, sensitivity or pain
- Failure of the dental procedure necessitating additional treatment
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I understand that as specific dental treatments are identified in my Treatment Plan, I may be provided additional information and consents which I will be asked to sign. I may also ask for a copy of this signed consent should I desire it for my personal records.

Signature: _____ Date:_____

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