MILLER
FAMILY DENTAL

GENERAL CONSENT FORM

Name: _____ **DOB:** _____

Consent to Treatment: Please read and understand the following.
I do hereby authorize and request the performance of dental services and the use of procedures Dr. Kari Miller and/or her staff with Miller Family Dental may deem necessary for treatment. I understand that Dr. Miller and her staff will use clinical and patient management techniques that are reasonable, necessary, and advisable. I understand there are risks, benefits and alternatives to dental treatment. I understand that potential complications include, but are not limited to sensitivity, pain, swelling, bruising, temporary limited opening, muscle and joint tenderness, infection and need for further treatment including root canal therapy or tooth breakage and loss resulting in extraction. In some cases, teeth can respond negatively to any dental treatment and may require further treatment (root canal, extraction, crowns) that is unexpected or unforeseen. Drug and chemical reactions are possible to dental materials and medications commonly used in dentistry. This may result in an allergic or sensitivity reaction. Swallowing or inhaling small objects is possible during treatment. I understand there are risks to hard and soft tissues in the area. I understand that treatment failure is possible and that there is no guarantee for a successful result. I understand adverse effects are possible and may be immediate or delayed. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases nerve damage may be possible resulting in permanent anesthesia.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of my dental needs. Once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. I understand that my treatment plan may change pending clinical findings. I will be advised of any changes.

In the event that Dr. Miller or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

I understand that dental treatment is a form of surgery and that my teeth or the surrounding areas may have post-operative sensitivity for a period of time. I understand that minor adjustments may be necessary after treatment for better comfort.

While we follow procedural guidelines, which most often lead to clinical success, there are occasional cases, as in any medical treatment, that do not turn out as planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

_____ _____

Patient/Legal Guardian Signature Date

YOU MAY REQUEST A COPY OF THIS CONSENT

Miller Family Dental
695 S. Colorado Blvd. Suite 220 - Denver CO, 80246
T: 303-698-0476 E: millerfamilydentalCO@gmail.com