# PATIENT TREATMENT CONSENT FORM

I acknowledge that Wohl Family Dentistry, LLC holds my health and wellbeing in the highest regard and the doctors and staff commit themselves to provide the highest level of comfort and success possible. I understand that there are risks involved in some routine – and generally very safe – dental procedures. I understand that despite estimates of the success of any dental procedure, there are personal biologic factors that cannot be predicted in advance that may affect its success.

The following procedures and some of their possible complications are among those services that may be offered to me by Wohl Family Dentistry, LLC.

The use of local anesthetics, nitrous oxide sedation, and antibiotics, although generally very safe and effective involve the potential of some risks. As for all medications, they may cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting, and/or anaphylactic shock. Local anesthesia may produce slight irritation or soreness at the site of the injection which is temporary. Rarely a prolonged loss or disturbed sensation of the lip or tongue may occur, and if it does it frequently resolves.

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require an extraction. Although root canal therapy has a very high degree of success, many factors contribute to its success or failure which may not be determined in advance. Therefore, a tooth which has had root canal therapy may require re-treatment, surgery, or extraction.

I understand there may be times when an extraction of a tooth or teeth is necessary. Generally, there will be a period of some discomfort, some swelling and some bleeding may occur after a tooth is extracted. Although rare, some other risks include post-operative infection and possible injury to adjacent teeth or structures.

I understand that individual reactions to treatment cannot always be predicted and that if I experience any unanticipated results or reactions following treatment, I agree to report them to the office as soon as possible. I also understand that the success of my dental treatment depends in part on my cooperation and understanding of post-operative instructions, and I will discuss any questions I have regarding my treatment and possible outcomes with one of the Doctors.

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Printed Name

_____ _____

Patient/Guardian Signature Date