

“Smiles change lives ...
and we change lives everyday.”

Patient Name: _____

Today's Date: ____/____/____

ALL PATIENTS MUST READ, AND SIGN THIS FORM VERIFYING A FULL
UNDERSTANDING AND ACCEPTANCE OF THE TERMS BELOW.

I am informed and fully understand that inherent in any type of dental treatment are certain unavoidable complications. The following are the most common but do not constitute a thorough and complete list. Post operative discomfort, pain, bleeding, swelling or bruising. You may experience stiff or sore jaws and / or jaw joint, loss of injury to adjacent teeth and / or soft tissues, including any nerve disturbances that may include numbness in any area of the mouth.

I request and authorize Steve Childress II, DDS, PLLC and his staff to do whatever Steve Childress II, DDS, PLLC and his staff deems advisable if any unforeseen condition arises in the course of any operation(s) and / or procedure(s) calling, in their judgement, for procedures in addition to or different than those discussed and agreed upon. I am aware that it is standard practice that Steve Childress II, DDS, PLLC or his staff will make me aware of any changes in the procedures that need to be performed so long as I am of the capacity to listen and respond.

In spite of the possible complication and risks, the agreed upon operation(s) and / or procedure(s) are necessary and desired by me, whether they are considered necessary or elective by others. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure.

I have provided an accurate and complete medical and personal history, including all medications I am currently taking, the amount and frequency of each medication, as well as, the reason my physician has prescribed this medication.

I have listed all allergies, past and present.

I will follow any and all instruction as explained and directed to me by Steve Childress II, DDS, PLLC and his staff and I will permit any prescribed diagnostic procedure.

I have had the opportunity to ask questions and receive answers to all questions about the procedures to be performed. I am aware that at any time, I am encouraged to ask questions pertinent to any procedure. Steve Childress II, DDS, PLLC will always discuss the best treatment options, as well as, any alternatives with me.

Signature of Patient, Parent, or Guardian

____/____/____
Date

Printed Name of Above Signed

Treatment Consent - General