CONSENT TO DENTAL TREATMENT

I, _____

Address: _____

Phone/email _____

REQUEST AND AUTHORIZE:

Robert E. Harris, Jr., DMD, his Dental Hygienists and Dental Assistants to provide treatment for:

Patient Name_____

Using the following procedures and other procedures as needed:

- Clinical Examinations
- Radiographic (x-ray) examinations
- The use of ozonated water, ozonated olive oil, ozonides and oxygen/ozone gas mixtures to disinfect the mouth, soft tissues, (gums, cheeks, tongue and associated structures) tooth structure, root canals, dental implants, extraction sites, and any infections in the oral cavity or associated structures .
- Dental Cleaning Procedures, including: a) Scaling the teeth (removal of hard deposits) with hand instruments or ultrasonics. b) Root Planing of the teeth. (removal of hard deposits from root surfaces) c) Polishing the teeth.
- Removal of tooth structure and previous restorations (old fillings, crowns and bridges) as required for restoring (filling or crowning) cracked, fractured or decayed tooth structure.

I understand that unknown things can happen during treatment and may require a change in the procedure I am having done. I consent to change to another procedure that may be necessary to finish the procedure. (For example: during the removal of decay from the tooth for a filling, the nerve may be exposed and I may need a root canal or extraction **OR**, a piece of tooth, filling material or appliance can break and a piece can be aspirated requiring a surgical procedure)

I consent to the proposed treatment plan (see attached treatment plan) and any changes to the plan that I talk about with Dr. Harris, after confirming that I have been told about the risks, advantages and disadvantages of the treatments and what may happen by not performing the procedures. (Example: not extracting or performing a root canal on an infected, abscessed tooth)

I consent to taking prescribed prescription pharmaceutical medications. I consent to taking recommended nutritional products.

I consent to the injection and administration of local anesthetics and oxygen/ozone gas. I understand that there is an element of risk with the injection of any injectable agent. These risks include, but are not limited to: adverse drug reactions, allergic

reactions, cardiac arrest (heart stops beating) , tachycardia (very fast heart beat), swelling, bruising, pain, transient or permanent nerve damage (numb lip, etc.), asthmatic reactions (difficulty breathing), needle tract infection and other unspecified injuries.

I consent and agree to the treatment that I am asking Dr. Harris to perform. I know there are risks in any dental procedure that is performed. I know that the practice of dentistry is not an exact science. I understand that there has been no warranty or guarantee that the treatment and results I want will be successful.

I have been offered an explanation of my proposed treatment and all the statements in this consent form. I had the opportunity to ask questions concerning my proposed treatment and the information in this consent form. I am satisfied that I understand everything in this consent form.

Patient or Guardian Signature _____Date_____

Dentist Signature _____Date_____

Witness Signature _____Date_____

November 2012