DESIGNER SMILES

Dr. Jeffrey Harrie
3525 25th Street South
Fargo, ND 58104

701-298-9400

CONSENT FOR EVALUATION / ASSESSMENT / TREATMENT

I hereby authorize doctor or designated staff to perform Oral Examinations / Assessments, take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of

_____'s dental needs.
(patient's name)

I understand that the purpose of any recommended treatment is to correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment, my present condition will probably worsen in time, with potential risk to my overall oral health, as well as my overall general health.

I have been informed of possible alternative treatment, if any.

I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance, such operative risks may include, but are not limited to: postoperative discomfort and swelling; bleeding that may be prolonged; injury to adjacent teeth and/or metal restorations; postoperative infection requiring additional treatment; restricted mouth opening for several days; additional extensive surgery to remove a root tip; nerve injury resulting in temporary or permanent numbness to lip, chin, gums, teeth and/or tongue; displacement of tooth or root, sinus or cavity requiring additional surgery; opening of sinus (normal cavity above upper teeth) requiring additional surgery; stretching of the corners of the mouth with resulting cracking and/or bruising.

Medications and prescriptions may cause drowsiness and lack of awareness and coordination, which may be increased by the use of alcohol or other drugs. I have been advised not to work or operate any vehicle or heavy machinery while taking medication and/or drugs, until fully recovered from the effects of same.

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents, analgesics, and other medications to allow for patient comfort during a procedure can cause allergic reactions including, but not limited to, redness and swelling of tissues, pain, itching, vomiting and anaphylactic shock.

If I have received a local anesthetic (been numbed) for a treatment appointment, I am aware that it may reduce my ability to control swallowing and may increase the chance of swallowing a foreign object during or after treatment. I understand that the numb feeling will normally remain for 2 to 4 hours following treatment, unless I have been given a long acting local anesthetic which may last for 8 hours or more. While my mouth is numb, I understand that I should not eat, bite on or play with my teeth, lips, cheeks, or tongue to avoid substantial injury to these structures. I understand that I may not chew anything until all of the feeling has returned to my mouth, teeth, lips, cheeks and tongue. I understand that for the day of my appointment, I should only eat soup or some other soft food that does not require much chewing. Watch children carefully and repeatedly remind them not to bite themselves. I also understand that temporary numbness and/or tingling of the lips, cheeks and tongue may result from anesthesia injections. In much less frequent cases, the numbness and/or tingling may be permanent.

If any unforeseen condition should arise in the course of the procedure calling for the doctor's judgment, or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever may be deemed advisable.

No guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I will have the opportunity to discuss my treatment plan and alternative treatments with the doctor. I will be given ample opportunity to ask questions and have them answered to my satisfaction.

I understand it is my responsibility to inform the doctor and/or appropriate staff members of any changes in my health status, or any changes in my medications. I have had the opportunity to discuss with the doctor my medical and health history, including any serious problems or injuries.

I give consent to the doctors' or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to prove quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

_____

Patient / Parent / Guardian Signature

Date