Amanda M. Hillis, D.D.S.
7421 Mexico Road, Suite 202
Saint Peters, MO 63376
(636) 970-7902

General Dental Treatment Consent

Patient Name: _____

1. I request and authorize Dr. Amanda Hillis to perform the treatment and procedures outlined on the Treatment Plan.

2. I further request and authorize the taking of oral-dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by to diagnose and/or treat my dental problem(s).

3. I have had explained to me, and I have had sufficient opportunity to discuss my dental condition/ problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

4. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include, but are not limited to, the possibility of pain or discomfort during and following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a transient or permanent temporomandibular joint (TMJ) disorder, opening of or displacement of a tooth or portion thereof into the sinus (a normal cavity situated above the upper teeth) or other anatomic location requiring additional surgery to close the opening or recover the tooth structure, temporary or permanent numbness, and allergic reactions.

5. I understand that during the course of my/the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on my Treatment Plan. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made concerning the results of the dental treatment that l/the patient will receive.

6. WOMEN ONLY: If on birth control pills, it is IMPORTANT TO UNDERSTAND that ANTIBIOTICS have been reported to decrease oral contraceptive effectiveness, resulting in a CHANCE OF UNPLANNED PREGNANCY, if antibiotics are prescribed, other contraceptive methods are recommended if pregnancy must be avoided.

7. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for me on the Treatment Plan.

8. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

9. I confirm that I have read this form, or it was read to me.

Patient Signature:_____ Date: _____