ADAM J. BARR, DDS
Cosmetic & Family
DENTISTRY

Informed Consent to Perform General Dentistry

All PATIENTS PLEASE READ AND SIGN BELOW

1. WORK TO BE DONE: I authorize Adam J. Barr, DDS and/or dental auxiliaries of his choice to perform diagnostic and preventative treatment including but not limited to examinations, radiographs (x-rays), preventative hygiene cleanings (prophylaxis), application of fluoride, and sealants. If recommended and after discussion, I authorize the treatment of diseased or injured teeth and gums with dental restorations, root canals, and/or removal of teeth, the replacement of missing teeth with dental prostheses, and scaling and root planing. I understand that there are risks involved in any treatment and hereby acknowledge that these risks have been explained to me and that I will have an opportunity to ask questions regarding the risks, benefits, and alternatives of all treatment options, including no treatment.

2. DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swelling, pain, itching, and/or anaphylactic shock. I agree to the use of local anesthesia. I understand there are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. Although rare, unexpected severe complications with anesthesia can occur and include the possibility of infection, swelling, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. If needed, I agree to the use of sedative drugs to combat apprehension and/or disruptive behavior.

3. TREATMENT PLAN: I understand that all proposed treatment along with associated risks, benefits, and alternatives will be discussed with me and any and all questions will be answered before any work is to be done. The patient and the doctor together will develop a treatment plan to address the patient's concerns. I understand this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

4. RECORDS: I authorize the use of photographs, radiographs, other diagnostic materials, and treatment records for the purposes of consultation with other dental professionals and/or medical doctors.

5. SUCCESS: I understand the success of the dental treatment to be provided will require that the patient follow the post-operative and post-care instructions given by the dentist and/or the dental auxiliaries and that proper home care and regular hygiene and dental visits as scheduled by my dentist and his dental auxiliaries must be maintained. I acknowledge that no guarantee or assurance has been made by anyone regarding the results of the dental treatment which I have requested and authorized.

6. I hereby state I have read and understand this informed consent form, and that all questions about the procedures have been answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise before, during, and after the course of my treatment. I hereby authorize the dentist and/or dental auxiliaries to proceed with and perform the dental procedures and treatments as have been explained to me.

Patient Name _____ **Adam J. Barr, DDS**

Patient/Guardian Signature_____ **Dr. Signature**_____

DATE _____ **Witness** _____