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INFORMED CONSENT

DENTAL TREATMENT

Patient name (print): _____

Date: _____

After reviewing your health history, the doctor will examine you and may require x-rays to make an accurate diagnosis and treatment plan. The doctor will select a treatment plan which best suits your needs. You will be informed of all alternative treatment available to you. Occasionally the plan may have to be altered during treatment, due to unexpected changes. Any vital tooth may require a root canal treatment if it becomes sensitive after being treated. We encourage you to ask the doctor any questions you may have so you understand your condition.

At this time we would like to inform you of risks that are uncommon but could occur from dental treatment. They are as follows: Soreness, allergic reactions, reaction to injections, pain, infection, continued numbness, laceration and swelling. Prescribed medication and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol and other drugs) thus, is advisable not to operate any vehicle or hazardous device, or to work for twenty-four hours or until recovered from their effects. Antibiotics may interfere with oral contraceptives and caution should be used during antibiotic use.

If there is anything you do not understand, please discuss it with the doctor before signing the statement below.

I certify the information I provided for the health history is true and factual to the best of my knowledge. I understand the risks of dental treatment, which was supplied in the statement above. Any additional information which may occur will be supplied to you.

AFTER READING AND UNDERSTANDING THE ABOVE RISKS FOR TREATMENT, I HEREBY GIVE CONSENT FOR DENTAL TREATMENT.

Patient signature: _____

Date: _____

Patient guardian if under 18: _____ Relationship: _____

Witness: _____

Date: _____

