JESSE C. BRADFORD, D.D.S., P.L.L.C.

GENERAL & FAMILY DENTISTRY

Information and Consent Form

I hereby authorize Jesse C. Bradford, D.D.S., P.L.L.C. and whomever he may designate as his assistant or hygienist to perform those dental procedures which have been discussed. I have been advised of alternate treatment plans that may be available. I consent to the treatment plan that I have accepted. If any unforeseen condition arises in the course of these procedures, I understand that additional and/or alternate procedures may be required. Dr. Bradford or his staff, will always advise me of any changes. I further request and authorize the dentist to do what he deems advisable.

I am informed and fully understand that there are certain risks in any dental treatment. These risks may include, but are not limited to: post-treatment sensitivity, pain or throbbing, pulpal inflammation, fracturing of new or existing restorations, swelling, temporomandibular (jaw) joint dysfunction, changes in occlusion (bite), sensitivity to the teeth and gums during and after cleanings, delayed healing and treatment failure. I also understand there are certain risks and consequences if I do not inform my dental care provider of updates or changes in my medical or dental history.

I understand that there are certain risks more specific to oral surgery procedures. The most common risks include post-operative bleeding, swelling, bruising, discomfort, trismus, and loss or damage of existing restorations. Other less common complications include, but are not limited to, infection, sinus exposure, aspiration of teeth or restorations, nerve disturbances, and small root fragments remaining in the jaw which may require additional surgery for removal. These complications are typically transient, but in rare cases, may be permanent.

I further consent to the administration or prescription of any drugs that may be deemed advisable or necessary in my case including, but not limited to the following: anesthetics, antibiotics, analgesics, anxyolytics and nitrous oxide sedation. I understand that certain prescribed medications and drugs may cause drowsiness and lack of awareness and coordination. I understand that there is an inherent risk in the administration of any anesthesia which includes, but is not limited to the following: adverse drug response, allergic reaction, hematoma, cardiac arrest, pain, bruising, and injury to blood vessels and nerves.

A more complete explanation of all complications is always available to me upon request. I have been given the opportunity to ask questions regarding my treatment, and the questions that I have asked have been answered to my satisfaction. I understand that my treatment is necessary and/or desired by me. Every reasonable effort will be made to ensure that my condition is treated properly. I have not asked for, nor received a guarantee of the outcome of these procedures. I understand I am entitled to a copy of this consent form.

_____ _____

Patient/Parent/Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

Jesse C. Bradford, D.D.S., P.L.L.C. is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of Jesse C. Bradford, D.D.S., P.L.L.C.'s Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

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Employee signature *Date*

Revised 02/18/2014