topdown dental
Nancy Nehawandian, DDS
healthy mouth healthy body healthy life

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CONSENT TO PERFORM DENTISTRY

_____I hereby authorize and direct the dentist(s) of Dr. Nancy Nehawandian's office and/or dental auxiliaries of her choice, to perform any dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

_____I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

_____I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

_____I agree to the use of local anesthesia as deemed necessary by the dentist(s). I understand the possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the infection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare and potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

_____I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits, as scheduled by my dentist and her auxiliaries, must be maintained.

_____I realize emergencies do arise, but in case of numerous failed or broken appointments, I will not be able to pre-schedule any appointments.

_____I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of marketing, teaching, research, and scientific publications.

_____I acknowledge that Dr. Nehawandian provided me a copy of the Dental Materials Fact Sheet.

_____I acknowledge that Dr. Nehawandian provided me a copy of the HIPPA-Notice of Privacy Policies.

I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

Patient's Name: Witness:

Name of Parent or Guardian:

Relationship to Patient:

Patient or Responsible Party Signature

Date