John Shoemaker, DDS, DICOI

DENTISTRY

GENERAL, IMPLANT AND COSMETIC

Board-certified International ICOI

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CONSENT FOR DENTAL TREATMENT

Please read this consent form carefully and ask about anything that you do not fully understand.

I, ________________________, voluntarily request Dr. Shoemaker and his staff to treat my dental needs which may include:

- Cleaning of the teeth & the application of topical fluoride.
- Treatment of diseased or injured teeth with dental restorations (which may include, fillings, crowns or root canals).
- Removal of one or more teeth (extractions, simple or surgical).
- Replacement of missing teeth with dental prosthesis (including bridges, dentures, partials or implants).
- Treatment of diseased or injured oral tissue (hard and/or soft).
- Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
- Any other procedures, including but not limited to x-rays, the use of local anesthetics and diagnostic photos deemed necessary for the purposed planned treatment.

Alternate forms of treatment, as well as the option of no treatment, have been explained to me with the advantages, disadvantages, risks and probable effectiveness of each. I have been advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore; there can be no guarantee as expressed as to the result or as to cure. Although the occurrence is extremely rare, some risks are known to be associated with any dental procedure and/or anesthetic. I further understand and accept that though unlikely, complications may require further medical attention outside this office. If a legal dispute arises, any dentist rendering an opinion on treatment performed in this office must have similar credentials.

- ☐ I hereby state that I have read and understand this consent that I have been given an opportunity to ask any questions I might have and that all questions have been answered in a satisfactory manner. I further understand that this consent will remain in effect until such time that I terminate it in writing.

- ☐ I understand that I will be informed of specific treatment needed prior to treatment being performed.

____ ____________________

Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)