The Graceful Smile Dental
49 E. Main St
Milan, MI 48160
Tel: 734-508-7088

General consent for dental treatments

1. I, _____ authorize _____ of The Graceful Smile Dental along with associated professionals to perform upon the above named patient any and all procedures, including but not limited to: local anesthetic, x-rays, examinations, teeth cleaning, restorations (fillings, crowns or bridges), extractions, and any procedures that in their judgment to be necessary or advisable for the above patient's well-being and safety.
2. I acknowledge that the nature of my condition and the essence of the proposed health care procedure, together with any alternative method of treatment or non-treatment, have been thoroughly explained to my satisfaction including the chance of substantial risk or harm.
3. I acknowledge that I had opportunities to ask questions about the health care procedures, their alternatives, and / or complications.
4. I acknowledge that my questions have been answered in a satisfactory manner, and that I understand the attendants risks involved and voluntarily assume them.
5. It has been explained to me, that during the course of such procedure(s) or operation(s), unforeseen conditions may be revealed which necessitate either an extension of aforementioned procedure(s), or modification of them. I authorize and do request that Dr. _____ and associated dental professionals perform any such additional procedure(s), or modifications of them.
6. I have been advised of the following potential complications from oral surgery, extractions, root canal treatment, periodontal surgery and anesthesia and related procedures: Common complications including but not limited to: pain, infections, swelling, bleeding, bruising, discoloration, uncommon complications including but not limited to: temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek and/or teeth; injury to or stiffness of the neck and facial muscles; changes in occlusion and/or temporomandibular joint: possible injury to teeth restorations and tissues adjacent to the tooth being treated; referred pain to ear/ head and neck, nausea, vomiting, allergic reaction, fractured bone, delayed healing and "dry sockets", opening into the sinus or nose during and/or following extractions and/or surgery.
7. I acknowledge that I have provided complete and accurate health history and have informed Dr. _____ & associated dental professionals of all major medical and/or pathological conditions or diseases no matter how insignificant or small the problem may be and informed Dr._____& associates of all medications, prescriptions and over the counter drugs (including: aspirin, Tylenol, cold remedies, etc.) and that I am now taking or have taken in the past month. I hereby accept the responsibility to update and correct my health history and medications charted at each and every visit with Dr. Wang and associated dental professionals.
8. I understand that a reputable doctor cannot guarantee any specific results. No guarantee or assurance has been given by Dr. _____or associated dental professionals of the expectations of results that may be achieved.
9. I recognize that Dr._____ & all associated dental professionals are extending dental services beyond the expected standard of availability for my convenience, comfort and/or physical requirements. I cannot sign away my right to legally pursue any perceived personal wrong but agree that only acts or omissions which are grossly negligent or are willful and wanton will be considered grounds for legal remedy.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desire results, which may or not be achieved, for my benefit of the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. I accept and trust Dr. _____ & all associated dental professionals as my dentist. I believe that the only considerations in Dr. _____ & all associated dental professions mind, other than to perform high quality dental services are my personal right to choose and the right to benefit from their best efforts on my behalf. They also work to ensure that I have informed decision-making and consent. I believe that Dr. _____ & all associated dental professionals will try to do their very best under possibly trying circumstances. I believe and accept that his/their treatment will represent his/their best judgement. I believe that this is the essence of the professional relationship and voluntarily enter into it. I specifically authorize the following as dictated by Dr._____ professional judgements: Exam; necessary x-rays; cleaning of teeth; cavity restoration; endodontic procedures; prosthetic restoration; extractions to treat pain and/or infections; and orthodontic treatment.

Patient Date