OZARKS COMMUNITY HEALTH CENTER
MEDICAL • DENTAL • BEHAVIORAL HEALTH

DENTAL CONSENT

Dental Treatment Consent Form

Consent for X-rays

In providing the best possible dental care for you, we may need to expose and evaluate x-rays to help us with proper diagnosis. With use of a lead shield, dental x-rays provide minimal radiation exposure and provide valuable information necessary for your health.

____ Yes, I agree and accept x-rays for proper diagnosis.

Local Anesthesia Consent

I understand that local anesthesia is often used during the dental treatment. This consent form is designed to make you aware of the following risks involved with local anesthesia. These include but are not limited to:

- It may affect your body such as dizziness, nausea, vomiting, increase or decrease in heart rate, or allergic reactions, which may require medical management or hospitalization.
- Restriction in mouth opening called trismus, at the site of injection requiring physical therapy.
- Prolonged numbness sometimes causing injury from biting or chewing on areas such as lips, cheek, or tongue.
- Injury to nerves can result in pain, numbness, tingling, or other sensory disturbances to the chin, lips, cheek, gums, or tongue. This may persist for weeks, months, years, or very rarely permanent.

Treatment Consent

I authorize the dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a proper and thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist to perform all recommended treatments, procedures, and medication administrations as prescribed by the dentist and agreed upon by me, or my legal guardian, I understand that during treatment it may be necessary to change or add procedures because of conditions found while treating the teeth that were not discovered during the examination. I give my permission to the dentist to make any/all changes and additions as necessary.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

I understand that in some instances my oral screening, teeth cleaning, fluoride treatments, x-rays, and sealants may be performed by a dental hygienist without the presence or supervision of a dentist as permitted by law under §332.311 of the Revised Statutes of Missouri (2006) and 19 CSR § 10-4.040. In this case, a dentist of Ozarks Community Health Center may perform an examination via our secure Electronic Medical Record (EMR).

Risk of Aerosols

Dental procedures create water spray which is how some viruses/bacteria spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours. After every appointment operatories are thoroughly cleaned with disinfectants effective against viruses and bacteria to help reduce the risk of viruses/bacteria being passed to others. If you start feeling ill with the symptoms of COVID-19 within 14 days of your appointment, call the dental office. You may have already been carrying the virus at the time of your appointment, so anyone who came into contact with you during the time could be at risk of getting sick too.

Patient/Guardian Signature: ______________________________ Date: ____________________

Parent Name (printed): ______________________________ Date: ____________________

Witness Signature: ______________________________ Date: ____________________