John A. Hendry, D.D.S.
Kathleen Adley Darnall, D.D.S.

& Associates
A PROFESSIONAL DENTAL CORPORATION

CONSENT FOR DENTAL TREATMENT AND
ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please feel free to ask us any questions you may have in regards to your child's treatment.

The following treatment(s) are being recommended for: _____
(PRINT PATIENT NAME)

☐ Examination	☐ Dental Restorations	☐ N2O (Nitrous gas)
☐ Prophylaxis	☐ Extractions	☐ Lidocaine
☐ Fluoride	☐ Sealants	☐ Sedation
☐ X-Rays	☐ Electrosurgery	☐ _____

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:
Any alternatives to the recommended treatment, including no treatment, have been explained to me, as well as the advantages and disadvantages of each.

RISKS ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:
I understand that dentistry is not an exact science and complications may occur despite our best efforts.
A partial listing of the risks known to be associated with the dental treatment and the anesthetic are:

- Infection
- Bleeding
- Failure of wound to heal
- Injuries to adjacent teeth and/or hard or soft tissues
- Paresthesia or numbness of : tongue, and/or mouth, and/or face
- Fracture of mandible (lower jaw) or maxilla (upper jaw)
- Opening between mouth and sinus or mouth and nose.
- Tooth or fragment in maxillary sinus
- Incomplete removal of tooth
- Dry socket
- Loss of teeth
- Loss of bone
- Slough (unanticipated loss of hard and/or soft tissue)
- Injury to adjacent structures
- Instrument Breakage
- Breakage of root(s) and retained root fragments
- Swallowing and/or aspiration of objects
- Allergic reaction to drugs
- Trismus (Jaw pain or difficulty opening mouth)
- Failure of treatment to accomplish its purpose
- Bacterial Endocarditis
- Additional oral surgery, hospitalization and/or further treatment may be required in the event of any complication(s).

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State Law also requires that I specifically advise you that although rarely occurring, the dental treatment or anesthetic may result in: Death, Brain Damage, Quadriplegia, Paraplegia, Loss of Organ(s), Loss of Function of an Organ, Loss of Function of Face, Arm(s), or Leg(s) and Disfiguring Scars.

ACKNOWLEDGEMENT

I, being the parent or guardian of the above minor patients, do hereby authorize and request the performance of dental services for this patient and the use of all procedures Dr. John A. Hendry, Dr. Kathleen Adley Darnall & Associates may deem necessary during treatment.

I acknowledge that I have read this consent from in full (or that it has been read to me) and I understand the information on both pages. I understand the information contained in it, including all of the technical terms (of which I have asked if unsure). I have been given an opportunity to ask any and all questions I have about the treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand the success of this treatment partially depends upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my following the pre-operative and post-operative instructions given to me, and keeping the appointments for treatment or follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complication(s). I understand that further treatment may be needed if unanticipated complications occur.

I hereby authorize and direct **Dr. John A. Hendry, Dr. Kathleen Adley Darnall & Associates** or assistants of their choice, to perform the diagnostic, restorative, surgical or dental procedures and patient management techniques including any anesthetic which may be deemed necessary and/or advisable by Dr. John A. Hendry or Dr. Kathleen Adley Darnall & Associates.

I understand that the treatment plan presented, along with the fees outlined, could change depending upon the elapsed time since the initial examination and extent of the dental work needed. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the named patient.

This Consent Form will remain valid until revoked by me in writing.

Patients Name: _____

Date of Birth: _____/_____/_____

Signature of Parent or Guardian: _____

Date: _____/_____/_____

Witness: _____

Chart# _____