

**Rick Friedrichs, D.D.S.**

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**DENTAL TREATMENT CONSENT FORM**

Patient: \_\_\_\_\_

By signing below, I understand that:

- a) A treatment plan will be presented to me, listing the procedures that will be done.

Initials \_\_\_\_\_

- b) This treatment plan may change during treatment based on conditions found while working on teeth that were not discovered during examination. I give permission to the Dentist to make any changes with further consent.

Initials \_\_\_\_\_

- c) Antibiotics and analgesics (pain medicines) may be prescribed at some point during treatment. These medications have the potential to cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Initials \_\_\_\_\_

- d) Local anesthesia is required for many dental procedures. Risks of local anesthesia include soreness of the injection site, muscle tenderness, bruising, swelling, and in rare instances nerve damage which can result in prolonged numbness.

Initials \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_