GENERAL CONSENT TO TREATMENT

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

GENERAL CONSENT TO DENTAL TREATMENT

I voluntarily consent to receive dental examination, diagnosis, and treatment from Dr. Keith Egan, DDS, Lakeside Dental, and any licensed dentists, hygienists, assistants, or other authorized clinical staff participating in my care.
I authorize the dental team to perform routine dental services that are considered necessary or advisable for my diagnosis, treatment, and ongoing oral health care, including, when appropriate:

- Comprehensive and limited examinations ● Dental cleanings and preventive care ● Periodontal evaluations
- Dental radiographs (X-rays), photographs, and digital imaging, including CBCT when clinically indicated
- Diagnostic tests ● Fluoride treatments ● Sealants ● Local anesthesia
- Nitrous oxide (when separately authorized, if applicable) ● Placement of temporary restorations or sedative dressings
- Routine restorative procedures ● Emergency treatment necessary to relieve pain, control infection, or prevent further injury

I understand that additional treatment recommendations may be made after my examination or as treatment progresses.

RISKS OF DENTAL TREATMENT

I understand that all dental procedures involve some degree of risk and that complications cannot always be predicted.
Possible risks may include, but are not limited to:

- Temporary or prolonged discomfort ● Swelling ● Bruising ● Bleeding ● Infection ● Tooth sensitivity
- Temporary difficulty chewing ● Jaw muscle soreness or fatigue
- Aggravation of temporomandibular joint (TMJ) symptoms
- Allergic or adverse reactions to medications or dental materials
- Temporary or, in rare cases, permanent numbness associated with local anesthesia
- Accidental injury to the lips, tongue, cheeks, or surrounding tissues
- Breakage of instruments or dental materials
- Swallowing or aspiration of small dental instruments or materials, which may require additional medical evaluation or treatment

Although uncommon, unforeseen conditions may be discovered during treatment that require changes to the planned procedure or additional treatment.

MEDICATIONS AND MEDICAL HISTORY

I understand the importance of providing complete and accurate medical information, including:

- Current medications
- Allergies
- Medical conditions
- Previous surgeries
- Pregnancy status, when applicable

I agree to notify Lakeside Dental of any changes to my health or medications.
I understand that certain medications, including bisphosphonates and other medications used to treat osteoporosis or certain cancers, may increase the risk of complications following oral surgery or tooth extractions.

NO GUARANTEE

I understand that dentistry is not an exact science. Although every reasonable effort will be made to achieve a successful result, no guarantee, warranty, or assurance has been made regarding the outcome or longevity of any treatment.

PROCEDURE-SPECIFIC CONSENT

I understand that certain procedures—including, but not limited to, dental implants, extractions, root canal therapy, periodontal surgery, intravenous or oral sedation, and other complex treatments—may require separate informed consent forms describing the specific risks, benefits, alternatives, and expected outcomes.

QUESTIONS

I certify that:

- I have had the opportunity to ask questions. ● My questions have been answered to my satisfaction.
- I understand the information provided. ● I voluntarily consent to the recommended examination and treatment.

PATIENT INFORMATION

Patient Name (Print):_____

Name of Parent, Legal Guardian, or Personal Representative if applicable :_____

Relationship to Patient:_____

SIGNATURES

Patient / Parent / Legal Guardian / Personal Representative
Signature: _____ Printed Name: _____Date: _____

Witness (Optional)
Signature: _____ Printed Name: _____Date: _____