CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Jo Ann Thiel, D.D.S., P.A. and/or dental auxiliaries of her choice, to perform dental treatment, including the use of any necessary or advisable local anesthesia, x-rays, or diagnostic aids.

2. I understand that there are risk involved in some treatments and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits suggested by my dentist and her auxiliaries must be maintained.

4. I recognized that during the course of treatment unforeseen circumstances may necessitate additional of different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, the in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I agree to the use of local anesthesia if needed and/or the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen occasionally produces nausea and vomiting. I understand and have been informed of the above risks and complications.

7. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

8. I further understand that this consent will remain in effect until such times choose to terminate it.

Print Name________________________________ Date______________________

Signature of Patient/Parent/or Guardian_____________________________________