WINTER

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INFORMED CONSENT AND TREATMENT CONFIRMATION

_____ _____

PATIENT'S NAME DATE

To my knowledge I have given an accurate report of my health history. Any prior allergic or unusual reactions, gum or skin reactions, abnormal bleeding, and any other conditions related to my health are included.

I have been informed and understand that occasionally there are complications from treatment and local anesthesia. Complications can include but are not limited to: pain, swelling, sensitivity, gum discoloration, bruising, infection, drug/anesthetic reactions and side effects, damage to adjacent teeth or fillings, post-treatment bleeding, failure of the dental treatment procedure necessitating additional treatment, breakage of dental instruments inside tooth canals making additional treatment necessary, and complications during treatment necessitating referral to a specialist.

I understand that photos, radiographs, and other records may be made during the course of my examination, treatment and follow-up care. I give my permission for such items to be used for purposes of education, research, or publication in professional journals or websites. I understand my identity will not be revealed (by name).

☐ Please indicate if no full facial photos may be used during educational programs by checking here.

I acknowledge that I have received a copy of 'Treatment Information and Facts' and have had the opportunity to ask questions and have them answered. I understand that I can get an explanation of all risks at any time during treatment simply by asking.

After an oral exam performed by Dr. Winter and with full understanding after discussion of all aspects of my dental treatment including potential modifications, I approve treatment as outlined by the doctor or his associates. I certify that I have read and understand all of this INFORMED CONSENT which outlines the general treatment considerations as well as the potential problems and complications of Restorative/ Prosthodontic treatment. I understand that potential complications and problems may include but are not limited to, those described in this document. I have been given the opportunity to ask questions about the proposed treatment and associated risks, as well as the potential consequences should I elect to postpone or refuse to implement care. I will be given an estimate and explanation of all fees associated with my treatment before treatment begins. I understand that conditions may occur during and following treatment that warrant additional or alternative care. I further understand that no guarantees can be made for a successful result.

SIGNED: _____ _____

DATE

RELATIONSHIP IF PATIENT IS A MINOR: _____

WITNESS: _____ _____

DATE