Divine Dentistry, LLC
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CONSENT FOR DENTAL TREATMENT

There are now legal requirements for us to obtain your consent for dental treatment. Please ask us about anything you do not understand and we will be pleased to explain anything and/or answer your questions. You may be asked to provide additional specific consent for particular dental procedures.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or premedications prior to dental care being rendered. Some of these risks and/or complications are, but not limited to the following:

- Severe swelling and bruising
- Paresthesia (permanent or transient numbness of the cheeks, gums, teeth, lips, tongue, chin and face)
- Loss of taste
- Allergic reactions to drugs
- Dry socket
- Heavy bleeding
- Instrument breakage
- Infection
- Pain
- Breakage of root(s) and loss of and/or damage to adjacent teeth and bone
- Sinus involvement
- Trismus (jaw pain or difficulty opening mouth)
- Failure of treatment to accomplish its purpose
- Further treatment and/or surgery
- Brain damage
- Death

ACKNOWLEDGEMENT

I acknowledge that I have read this form, or that it has been read to me. I understand the information contained in this consent form. I was given the opportunity to ask questions, and all of my questions and my concerns were addressed.
I understand that if I fail to show to a scheduled confirmed appointment that a $75 NO SHOW fee (not covered by insurance) will be my responsibility to pay. Also, not showing for scheduled treatments can cause dental issues to persist and worsen if they remain untreated. I understand that if I fail to show for a confirmed scheduled appointment that it is considered dismissing myself as a patient of record due to non-compliance or because I no longer opt to receive treatment at this facility, so no further appointments will be scheduled. I understand that it is my responsibility to make contact via email, phone call or voicemail two to three days prior my appointment in order to confirm that I will be present or to cancel/reschedule my appointment; if I fail to do so my appointment time is not guaranteed.
I hereby authorize and direct Dr. Dana M. Jackson and/or associates, hygienists, assistants of her choice to

render dental treatment to______________________________ (patient). The treatment rendered may be either diagnostic, surgical, and/or any form of treatment for which Dr. Jackson is licensed to perform. This consent form will remain valid until revoked by me in writing.

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Print Name **Signature of Patient or Parent/Guardian** **Date**