RULES AND INFORMED CONSENT FOR ANY TREATMENT

* I authorize the professionals involved, which using their best professional judgment; treat the diagnosed condition in my mouth as well as any conditions or unforeseen complication that occurs during treatment.
* I authorize also, if necessary, the application of local anesthesia that professional understands the most suitable for my case.
* It is impossible to guarantee medical or dental treatment. In any dental treatment there are potential risks and / or complications related to treatment. Among these are:

1. **If local anesthesia is used**: we can usually have numbness and/or tingling in the tongue and lower lip .There are usually transient, but rarely (0.008 %) may be permanent.
2. **In the case of operational treatment (treatment of caries):** pain or tenderness in the treated part, endodontic treatment requirements not covered by the initial treatment.
3. **In the case of surgery and/or extractions:** injury to adjacent teeth, communication between the mouth and the maxillary sinus (cavity in the upper teeth) which requires additional surgery, decision to leave part of the root if their removal requires surgery.
4. **In the case of crowns and bridges:** nerve damage from wearing part of the piece to place a crown and by that wearing requires endodontic treatment not covered by the initial treatment. Bite discomfort requiring selective treatment, cosmetic change that not meets with the expectations in the mind of the patient.
5. **In the case of endodontic treatment:** fracture of the tooth crown or root of the piece, separation of instruments hand inside the canal, periapical lesions unresponsive to preserved endodontic treatment and require a surgery.

**NOTE:** Negligent patient in meeting their appointments, directions to take antibiotic and specific postoperative recommendations are responsible for any complication(s) that arise as a result of this. All prescribed medication, including local anesthesia has the potential to cause adverse reactions, so call to this office to provide any feedback that you think is happening out of normal.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND ALL IN THIS DOCUMENT

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**Patient or guardian signature Date**

I certify that I have discussed this document with the patient and all the questions were answered.

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**Dentist signature Date**