

**EMERALD FAMILY DENTAL**  
**DR. OMAR AL-KAZAZ, DR. HESHAM FOUDA**  
259 Center Street  
Middleboro, MA 02346

General Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read the items below: I understand that during my course of treatment that the following care may be provided: Examinations, Radio graphs, Preventive Services, Diagnosis Services, Basic Restorative, Root Canals, Extraction, Surgery, Implants, Dentures, and Crowns. I understand that antibiotics, analgesics, and other medications can cause the following, but not limited to: allergic reactions, redness, swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

I understand that all dental and anesthetic procedures have associated risks. These may be, but are not limited to: Drug reactions and side effects. Damage to adjacent teeth or fillings. Post-operative infection .Post-operative bleeding that might require additional treatment. Delayed healing of an extraction site, (dry socket) necessitating additional care. Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date. Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas. Bruising, swelling, sensitivity, or pain .Failure of the dental procedure necessitating additional treatment .Breakage of dental instruments inside tooth canals making additional treatment necessaryComplications during treatment necessitating referral to a specialist I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fee(s) involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

I understand the above information and agree with its contents, this is my consent to allow and authorize My Dentist and/or his/her associate/Hygienist to perform dental treatment.

By signing this form, I am freely giving my consent to allow and authorize Emerald Family Dental to render any treatment necessary and/or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient's name (please print): \_\_\_\_\_

Signature of patient or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_