

**CONSENT FORM FOR GENERAL DENTAL PROCEDURES**

You 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.

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.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you should be aware that antibiotics might make oral birth control less effective. Please consult with you physician before relying on oral birth control medication if your dentist prescribes antibiotics. Do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment you signal your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**CONSENT FOR ANESTHETICS (LOCAL ANESTHETIC)**

I hereby authorize Dr. Gordon J. Roznik, to administer anesthetics to me. I have been informed of the usual side effects and have been informed of the advantages and disadvantages of anesthetics. I understand the risk of reactions, such as redness, swelling, pain, itching, vomiting, anaphylactic shock and/or permanent nerve damage or other unforeseeable complications which may result from the administration of anesthetics. I realize that in spite of the possible complications, the use of local anesthesia is necessary and desired by me.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

In an effort to control the increasing cost of dental care, any claims or disputes against this office shall be resolved by “binding arbitration”. By signing this agreement, the patient agrees with the office of Dr. Gordon Roznik, that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement including associates) shall be resolved by binding arbitration, by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge, and agrees that all such claims will be resolved as described in this section.