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CONSENT FOR LOCAL ANESTHETIC INJECTIONS

I, _____, hereby authorize Dr. _____ and staff to perform a local anesthetic injection(s).

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which can not be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent, may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injections(s), I agree to report them to the office as soon as possible.

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained. I have discussed all of the above with the doctor, and have had all of my questions answered.

_____ _____
Patient's Signature (If a minor, Signature of Parent/Guardian) **Date**

_____ _____
Dentist Signature **Date**

_____ _____
Witness Signature **Date**