THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

General Consent for Dental Treatment

Patients, patient representatives, parents and guardians please read this form carefully

I give my consent for examination and treatment at The Ohio State University, College of Dentistry.

I understand that I may withdraw consent and refuse treatment at any time before the treatment is provided.

This treatment may include, but is not limited to, the following:

1. Examination of the tissues of the mouth (including the teeth, tongue, throat, cheeks, probing of the gums, etc.);
2. X-rays;
3. Numbing the tooth, teeth, or gums;
4. Cleaning the teeth and other gum-related treatment; and,
5. Blood studies for infections (like HIV/AIDS, hepatitis, etc.) as needed for health worker safety (for example: needle stick, etc.).

I understand the following:

1. I may experience some problems during examination and treatment that my dentist cannot predict. These include but are not limited to:
    - pain, discomfort, or swelling lasting several days
    - infection and bleeding
    - injury to other nearby teeth, fillings, crowns, lips, and gums
    - short-term, long-term or permanent numbness of the teeth, gums, tongue, cheek, lip or chin
    - unplanned reaction to a drug, dental material, latex, etc.
    - jaw joint (TMJ) problems
    - breathing in or swallowing a dental instrument or dental material
    - unplanned reaction to local anesthesia
    - any complication may result in additional treatment
2. All records including x-rays, photos (including full face), recordings and drawings will remain the sole property of The Ohio State University College of Dentistry. These records may be used for teaching and publication.
3. There is no guarantee of treatment results.
4. It is my responsibility to follow the post-treatment protocols of the College of Dentistry.
5. Emergency treatment (for example: extractions) is ***not*** complete dental care. I understand that it is my responsibility to seek more dental care, after receiving emergency treatment, as recommended.

I am, or my parent, legal guardian or representative is, signing this consent. I was given the opportunity to ask questions about these risks. All of my questions were answered. I understand and give my consent for treatment.

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Patient Name

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Patient/Parent/Legal Guardian/Representative Signature

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Date