GentleDental
OF SILOAM SPRINGS

Consent for **Services**

INFORMED CONSENT

I authorize Gentle Dental of Siloam Springs, and their staff to take x-rays, study models, photography, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis. I further authorize and consent that the Doctor may choose and employ such assistance as he/she deems fit while making a diagnosis.

I understand that my oral health and recommended treatment will be discussed with me. I will be offered treatment options that address my most urgent needs first. I understand that treatment alternatives will be explained including the consequences of doing nothing to treat the underlying issue. I understand that it is my sole responsibility to maintain your oral health.

We will assist you in any way possible to facilitate your treatment. However, it is important that you comply with planned and recommended treatment and professional cleanings and periodic exams.

I understand that during treatment, occasionally any of the above problems may occur. These can include but are not necessarily limited to: Pain, tooth mobility, nerve damage, and or jaw pain. An injury resulting from the use of dental equipment is also possible; however, rare.

I understand that during injections (numbing), or extractions (tooth removal) there is a chance for paresthesia (persistent numbness in the tongue and/or cheeks). The paresthesia is usually temporary; however, can be permanent.

The staff at Gentle Dental of Siloam Springs strive to provide the highest quality of dental care. I understand that the warranty of services is based upon my commitment to at least 1 professional cleaning and exam at Gentle Dental per year. I understand that this guarantee of services becomes void if I fail to stay up to date with periodic exams and professional cleanings.

I understand that I will be asked to sign consent for specific procedures prior Dr. Wood administering anesthesia or happy gas. I understand that I will have any and all questions answered prior to any specific procedures. I understand that it is my responsibility to update the staff at Gentle Dental of Siloam Springs if there has been a change in my medical history, including new medications.

I give Gentle Dental permission to reach out by phone, email, or text to communicate any appointment information including: reminders, instructions, and/or post-procedure follow up.

I understand that I will sign any consent forms for my minor child prior to their schedule appointment, if I am unable to attend the appointment with them.

I understand that if I fail to notify nor show 3 times for a reserved appointment time(s), treatment may be discontinued and I have the risk of severing my healthcare relationship resulting in dismissal from Gentle Dental of Siloam Springs.

NAME OF PATIENT: _____ DATE: _____

SIGNATURE: _____

If Patient is a Minor: Printed name of Parent/Guardian: _____