UMPQUA COMMUNITY HEALTH CENTER

General Consent

Patient Name:

_____ **Date of Birth:** _____

_____ I give consent for myself/my child to receive dental treatment deemed necessary by the provider at Umpqua Community Health Center. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics.

_____I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reactions, changes in pain perception, or prolonged and possibly permanent anesthesia.

_____I understand that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I will receive. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated fees are my financial responsibility.

_____ I have been given the opportunity to ask any questions regarding this consent, my questions have been answered to my satisfaction. I voluntarily accept any and all risks, including those listed above, which may be associated with any phase of this treatment in hopes of getting the desired results, which may or may not be achieved. By signing this document, I give my consent to allow Umpqua Community Health Center's dental providers to render any treatment necessary and/or advisable to my dental conditions, including the prescribing and administering medications and/or anesthetics that are necessary for my treatment.

Patient/Legal Guardian Signature: _____Date: _____