Winston-Salem
Dental Care

Kenneth M. Sadler, DDS and Associates, PA
201 Charlois Boulevard, Winston-Salem, NC 27103
(336) 331-3500 www.wsdentalcare.com

REQUEST AND CONSENT FOR ROUTINE DENTAL TREATMENT, SEDATION AND PHYSICAL RESTRAINTS

1. I authorize Dr. _____, and/or associates or assistants on the staff of Winston-Salem Dental Care to provide routine dental treatment including examinations, fillings, cleanings, x-rays, extraction of baby teeth or teeth for braces. I also authorize the use of local anesthetics, laughing gas (when needed), and physical restraints (when needed), in performing such routine dental treatment.

   Patient Name: _____

   Any exceptions: _____

2. I understand that the anesthetics, laughing gas and physical restraints are necessary to assist the dentist in performing the dental treatment with increased patient comfort and cooperation.

3. I have been informed and I understand that there are associated risks with the use of local anesthetic agents and sedative drugs. The usual and most frequent risks include, but are not limited to: numbness, bleeding, nausea, vomiting, and allergic reactions.

4. The purpose and possible complications of the use of sedative drugs has been explained to me, as well as possible alternative methods of treatment and their advantages and disadvantages. I understand the purpose, usual and most frequent risks, and probable effectiveness of each method or approach to treatment, as well as the probable result if no treatment is provided.

5. I acknowledge that NO implied or expressed guarantee as to the result of any routine dental treatment or use of anesthetic or sedative drugs has been given to me.

6. I intend for this consent to remain valid for routine dental care during the time that I am a patient at Winston-Salem Dental Care.

7. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I believe that I have been given adequate information upon which to base an informed consent for routine dental care.

8. I confirm that I have read and understand this form, or that it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed below.

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By signing here, I indicate that I have the capacity to make and communicate health care decisions and that I am fully informed as to the contents of this document.

Signature of Person Giving Consent _____

Print Name _____ Date_____ Time _____
If other than the patient, indicate relationship _____

CONSENT CERTIFICATION

I certify that I have explained the nature, purpose, benefits, and the usual and most frequent risks and hazards of, and alternatives to routine dental treatment, sedation and physical restraints. I have offered to answer any questions and have fully answered such questions.

Signature of Dentist Certifying Consent _____

Print Name _____ Date_____ Time _____

WITNESS CERTIFICATION

I hereby certify that the patient/relative/guardian either: has acknowledged in my presence that he/she has received an explanation of, and alternatives to routine dental treatment, sedation and physical restraints, the usual and most frequent risks and hazards of, and the alternatives to routine dental treatment, sedation and physical restraints; has had all his/her questions answered, has given his/her consent, and has signed this form where indicated; or after the informed consent discussion and signature above, has answered "YES" to all of the following questions:

1. Did the doctor explain the routine dental treatment, sedation and restraints to you?
2. Have all your questions about the treatment and procedures(s) been answered?
3. Is this your signature on the consent form?
4. Have you given your consent to routine dental treatment, sedation and restraints?

Witness Signature _____ Date _____ Time _____

Print Name _____ Date_____ Time _____