CONSENT FOR TREATMENT AND RELEASE

1. I hereby authorize Benjamin Gerkin, DDS or the designated staff to take radiographs, study models, photographs and any other diagnostic aides or procedures deemed necessary by the doctor to make a thorough diagnosis of dental needs for my child or me.

2. Upon such diagnosis, and with full knowledge that complications can occur, I authorize the doctor to perform, any or all recommended treatment, including any oral surgery, mutually agreed upon by me and to employ such assistance as required to provide proper care for me or my child. Recommended treatment may include, but is not limited to:

I) Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
II) Application of sealants to the grooves of the teeth.
III) Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
IV) Replacement of missing teeth with dental prosthesis (bridges, partial dentures, full dentures and dental implants).
V) Removal (extraction) of one or more teeth.
VI) Treatment of diseased or injured oral tissues (hard and/or soft).
VII) Use of sedative drugs and/or nitrous oxide sedation to control apprehension and/or disruptive behavior.
VIII) Treatment of diseased teeth with endodontic procedures (root canal).

3. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

4. I agree to the use of anesthetics, sedatives, and other medication as necessary for me or my child. I fully understand that using anesthetic agents embodies certain risks. The most common of these risks are swelling, bleeding, pain, nausea, vomiting, bruising; tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications. Should any emergency arise, I further authorize Benjamin Gerkin, DDS and his staff to seek necessary medical treatment for my child or myself.

5. I authorize release or use of any information concerning my health care or my child's health care, including, but not limited to radiographs, pictures, models and/or records for the purpose of evaluation and administration of claims for insurance benefits, treatment by another doctor, education, practice promotions, or demonstration of possible treatment.

6. I authorize and agree that the success of the dental treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

7. I agree to allow the doctor to evaluate my credit record for the purposes of extending credit.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures have been answered in a satisfactory manner; and I understand that I have the right to be provided answers to the questions which may arise during and after the course of my treatment or the treatment of my dependent.

9. By signing this statement, I revoke all previous agreements to the contrary and attest to the accuracy of the information provided on the patient information sheet.

Patient's Name (Please Print)_____ Date_____

Patient or Guardian's Signature_____