Baechtold
FAMILY DENTISTRY

Dr. Lisette Baechtold D.M.D., M.S.
2006 Merchant Drive
Richmond, KY 40475
(859) 626-7977

Consent to Perform Dentistry

Patient's name: _____

1. HEREBY AUTHORIZE AND DIRECT Lisette Baechtold DMD MS and or dental auxiliaries of her choice, to perform the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
   A. Preventive hygiene treatment, {prophylaxis) and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
   D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures and implants).
   E. Removal (extraction) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and/or soft).
   G. Treatment of Joint or Myofacial muscle Dysfunction or trauma.
   H. Use of sedative drugs to control apprehension and/or disruptive behavior.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me that I will have an opportunity to ask questions regarding treatment and the risks, and that I fully understand the same.

3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or guardians of the patient follow the post-care instructions of the dentist. I agree that the success of the treatment requires that all post-care instructions be followed and that regular office visits as scheduled by my dentist or her auxiliaries must be maintained.

4. I recognize that in the course of treatment unforeseen circumstances may necessitate additional or different treatment 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

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these 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 or 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.

6. I agree to the use of local anesthesia and the use of nitrous oxide/ oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/ oxygen may occasionally produce nausea and vomiting. I am also aware that the nose-piece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

7. I also authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

8. I hereby authorize a registered dental hygienist employed by Lisette Baechtold, DMD having complied with all other state regulations to perform preventive dental care when Dr. Baechtold is not present.

9. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of any treatment.

10. I hereby authorize the doctor and/or staff to disclose my dental information to a parent or family member, or my physician and/or staff if necessary.

11. I further understand that this consent will remain in effect until such time that I choose to terminate it.

_____ _____

Signature of Patient or Representative Date