Dr. Kenneth Cho Dentistry

721 W. Whittier Blvd Suite A
La Habra, CA 90631
(562) 697-3008

Informed Consent for Dental Treatment

Patient Name: _____

Date:_____

I hereby authorize and direct the dentist of Dr. Kenneth Cho Dentistry to perform dental treatment or oral surgery procedure (s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids. 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 and extractions.

I understand that there are risks involved in dental treatment and hereby acknowledge that these risks have been explained to me, that I have had an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

The dental treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages, and risks of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated.

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.

I understand and have been informed that there are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling, numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, and lip and cheek biting, resulting in ulceration and infection of the mucosa.

By signing below, I state that I have read and understand the above terms and give my consent to receive dental treatment at Dr. Kenneth Cho Dentistry.

_____ _____

Patient Signature Date