BRANDI HOWARD-STICKEL
& ASSOCIATES, DDS, LLC

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# CONSENT TO PERFORM GENERAL DENTISTRY

1. I hereby authorize and direct Brandi Howard-Stickel DDS and dental auxiliaries of her choice to perform the following dental treatment or oral surgery procedure(s), 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)
    - **E.** Removal (extraction) of one or more teeth.
    - **F.** Treatment of diseased or injured oral tissues (hard and soft).
    - **G.** Use of sedative drugs to control apprehension and /or oral disruptive behavior.
    - **H.** Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

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 the treatment and the risks, and that I fully understand the same.

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. There are possible risks and complications associated with the administration of local anesthesia. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, 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 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.

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

6. I am advised that the success of the dental treatment provided will require that the patient and the parents follow postoperative and post-cure instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-cure instructions be followed and that regular office visits as scheduled by my dentist and her auxiliaries must be maintained.

7. 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 my treatment.

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

**Date** _____

**Print Patient's Name** _____

**Name of Parent or Guardian** _____

**Relationship to Patient** _____

**Signature: Patient, or Parent/Guardian** _____

**Witness** _____