STAR KIDS DENTISTRY

General Consent Form

I do hereby authorize and request the performance of dental services and the use of whatever procedures may deem necessary for treatment. These procedures include, but are not limited to: examinations, oral prophylaxis (cleanings), fluoride treatment, sealants, restorations (amalgam or composite fillings and crowns), periodontal treatments, extractions, space maintenance and the use of local anesthesia. I understand that Dr. Jackson, her associates and staff will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed appropriate by Dr. Jackson and her associates. I understand that the purpose for using local anesthesia may be therapeutic, diagnostic or for the treatment of facial pain. I understand that potential complications include, but are not limited to pain, swelling, bruising, temporary limited opening and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

I understand that I am responsible for attaining any current x-rays that may have been taken at a previous office. If I do not obtain them, I permit the retaking of any necessary x-rays.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time lapsed since the initial examination. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or change in treatment.

Blood Borne Pathogen Exposure Testing:

In the event that Dr. Jackson, her associates, or staff members are exposed to the patient's blood or other bodily fluids, I agree to have the patient's blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C (HPC) and/or human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner and would be made available only to the person who was exposed and the person would be advised of his/her rights regarding protected health information.

Patient/Guardian's Signature: _____

Print Name of Patient: _____ Date: _____