INFORMED CONSENT FOR TREATMENT
FOY DENTAL CARE, P.C.
Dr. Benjamin S. Foy

- I herby authorize Dr. Foy to designate staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the dentist to make a through diagnosis of myself or my dependents dental needs. Upon such diagnosis, I understand a treatment plan will be formulated. From this treatment plan, I will be provided with an estimate of cost of the treatment. However, I understand that this is only an ESTIMATE.
- I authorize Dr. Foy to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I also understand that, during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension or modification of the original procedure(s) or different procedure(s) than those originally planned. I therefore authorize and request that the doctors and staff of Foy Dental Care perform such procedures are necessary and desirable in the exercise of sound professional judgment and understand I will be responsible for the fees associated with such procedures.
- I understand that no dental treatment is completely without risk and that my dentist will take reasonable steps to limit any complications. Possible complications include, but are not limited to:
    - Post-operative discomfort and swelling which may necessitate several days of home recuperation.
    - Injury to adjacent teeth and fillings
    - Post-operative infection requiring additional treatment
    - Stretching of the corners of the mouth with resultant cracking and bruising
    - Restricted mouth opening for several days or weeks
    - Injury to the nerve underlying the teeth during anesthesia (shots) or extraction resulting in numbness or tingling of the chin, lips, cheek, gums and/or tongue on the operated side; this may persist for several weeks, months, or in rare instances, may be permanent.
    - Discoloration at the injection site or in rare instances bruising of the cheek close to the injection site.
    - Exposure of the nerve while preparing the tooth for a filling or crown.
    - The need for root canal therapy after restorative work (e.g. fillings, crowns) resulting from deep restoration or stress caused by multiple restorations to the same tooth
- I agree to the use of anesthetics, sedative, and other medications as necessary.
- I understand that it is important for me to understand the treatment being rendered, pros and cons of that treatment, and any possible alternative treatments.
- I understand that if I do not understand the proposed treatment, it is better to ask any questions I have before treatment is started.

Patient Name:____________________________ Date:___________________________

Patient, Parent, or Guardian Signature:___________________________________