GREENSPOINT DENTAL

12523 Greenspoint Dr
Houston TX 77060
281-876-2278

INFORMED CONSENT FOR TREATMENT

I authorize Dr Louis P. Bosse and his associates, hygienists, employees, and agents to perform the following treatment/procedure/surgery for me as recommended:

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After a thorough examination and diagnosis, I have been informed of the recommended treatment plan, alternative treatment, and the benefits and risks involved. I have also been informed of the risks of inadequate or non-treatment, and the fee(s). All of my questions have been answered to my satisfaction.

I understand that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of my treatment. A risk of failure, relapse, or worsening of my condition may result regardless of the efforts made during treatment. Additional or re-treatment is always a possibility. I recognize that long term success depends upon my cooperation and routine maintenance as well.

I specifically authorize my dentist to select alternative methods of treatment based on my condition as disclosed during the procedures authorized by my execution of this form, including conditions, which were unknown at the time this treatment began.

I understand that there are substantial risks and consequences that may be associated with any surgical, dental, diagnostic, or anesthetic procedure. I understand that not every conceivable hazard can be listed, but that the following possibilities exist, however infrequent or rare:

▪Excessive bleeding ▪Pain ▪Temporary or permanent numbness of the lip, tongue, or other facial area ▪Swelling ▪Infection ▪Allergic reactions to medications, anesthesia, ECT ▪Bruising ▪Exposure of crown margins ▪Sensitivity ▪Food impaction areas ▪Speech changes ▪Injury to adjacent teeth ▪Stretching of the corner of the mouth with resulting cracking, bruising and lip pain

Knowing these risks, I consent to treatment

Patient Signature _____ Date _____