PATIENT NAME_____

MARLO GRIESSER, D.D.S
11577 HIGHWAY SIX SOUTH
SUGAR LAND, TEXAS 77478

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct Dr. Griesser and any dental auxiliaries of her choice, to perform the following dental treatment or oral surgery procedures including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventative 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 or soft).
G. Use of sedative drugs to control apprehension and/or disruptive behavior.
H. Treatment of malposed (crooked) teeth and /or oral developmental growth abnormalities.
I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me. Such as: upon removing decay if there is a nerve exposure, or a tooth becomes sensitive and the sensitivity does not subside this would require endodontic treatment, this type of treatment Dr. Griesser does not perform and we would refer you to a specialist in which additional cost would be incurred. Once a root canal has been performed on a tooth it then will require a full coverage crown, which Dr. Griesser would place on the tooth. I understand I will be given the opportunity to have ask any questions regarding any of the above treatment and the risks and that I fully understand the same.

3. I understand 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. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the Doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

5. These are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection sites), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and 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.

6. I also authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research, scientific publications and advertising.

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

8. 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.

9. I understand and have been informed and explained by Dr. Griesser, that the teeth involved in the smile design will be reduced 2 millimeters to allow thickness of porcelain. Following the preparation of the teeth, the teeth will be etched, primed, and bonded with the temporary crowns and veneers.

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

Date:_____Time:_____a.m./p.m.

Patient's name:_____

Name of Parent or guardian:_____

Relationship to patient:_____

Signature: Patient or Parent or Guardian:_____

Witness:_____