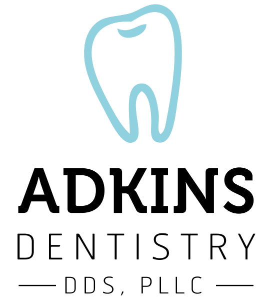
BRADLEY N. ADKINS, DDS, PLLC
2319 GRACE AVE.
NEW BERN, NC 28562



General Consent to Dental Treatment:

I, _________________________, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography. I acknowledge that Dr. Adkins or his associates will make every effort to explain the nature and purpose of proposed procedures and alternative options, but it is the patient's responsibility to ask questions and elect for treatment.

2. I authorize Dr. Bradley Adkins and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have legal responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

3. I voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results which may or may not be achieved for my benefit or the benefit of my minor child or ward. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I have the right to refuse any specific dental treatment, and voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with foregoing any dental diagnostic or treatment procedure.

5. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

___________________________________ ____________
Patient or Guardian Name Date

___________________________________ ____________
Witness Date