

**Niman Shukairy, DDS, Flushing Family Dentistry**  
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## **GENERAL CONSENT FORM**

I hereby authorize Dr. Shukairy and whomever he/she may designate as his/her assistants, to perform upon me the following operation and/or procedures:

I request and authorize him/her to do whatever he/she deems advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of a vein) , pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues) , jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

## **PATIENT INFORMED CONSENT FOR TREATMENT**

### **TREATMENT OPTIONS**

I acknowledge that all treatment options for my dental condition have been fully explained to me. It is my responsibility to complete treatment and follow recommended maintenance schedules. If I do not proceed with my treatment plan in a timely manner, maintenance plans are not followed and/or appointments are missed, adverse results could affect my dental health. Further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints will be based on our standard professional fees.

**TREATMENT FEES**

Fees are estimates only, are valid for 30 days from the date shown above and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

**ESTIMATED INSURANCE COVERAGE**

The estimated insurance coverage shown above is an estimate only, not a guarantee of payment or benefits. The patient is responsible for insurance claims not paid within 60 days of service.

**CONSENT**

I have reviewed the above estimate for treatment. I promise to pay the entire balance for any time, materials and laboratory expenses incurred in my behalf. I further understand that any balance over 60 days past due will be subject to small claims court and that I may be liable for any attorney fees incurred in collecting a delinquent balance.