



Welcome to Charlestown Dental
12 General Warren Blvd, Suite 400, Malvern, PA 19355

General Consent for Dental Treatment

PATIENT NAME _____ DATE _____

I give my consent for examination and treatment at Charlestown Dental. I understand that I may withdraw consent and refuse treatment at any time before the treatment is provided. This treatment may include, but is not limited to, the following:

1. Examination of the tissues of the mouth (including the teeth, tongue, throat, cheeks, probing of the gums, etc.);
2. X-rays;
3. Numbing the tooth, teeth, or gums;
4. Cleaning the teeth and other gum-related treatment; and,

I understand the following:

1. I may experience some problems during examination and treatment that my dentist cannot predict. These include but are not limited to:
 - pain, discomfort, or swelling lasting several days
 - infection and bleeding
 - injury to other nearby teeth, fillings, crowns, lips, and gums
 - short-term, long-term or permanent numbness of the teeth, gums, tongue, cheek, lip or chin
 - unplanned reaction to a drug, dental material, latex, etc.
 - jaw joint (TMJ) problems
 - breathing in or swallowing a dental instrument or dental material
 - unplanned reaction to local anesthesia
 - any complication may result in additional treatment
2. There is no guarantee of treatment results.
3. It is my responsibility to follow the post-treatment protocols of the office.
4. Emergency treatment (for example: extractions) is not complete dental care. I understand that it is my responsibility to seek more dental care, after receiving emergency treatment, as recommended.
5. The COVID-19 virus is a contagious disease classified by The World Health Organization as a pandemic. It's possible to contract COVID-19 from a variety of sources. We've taken steps to reduce the possibility of transmitting any disease in our office, including COVID-19. We've altered the frequency and timing of patient visits, and we follow social distancing protocols whenever possible. Our upgraded air purification systems, High Volume Evacuation, strict sterilization procedures, and use of Personal Protective Equipment dramatically lower the risk of disease contraction in our setting: It does not eliminate the risk. I understand and accept the risks associated with contracting COVID-19 from dental care in this office. I also acknowledge that I could contract the COVID-19 virus before or after my visit from other sources. I agree to continue with my dental care.

I am, or my parent, legal guardian or representative is, signing this consent. I was given the opportunity to ask questions about these risks. All of my questions were answered. I understand and give my consent for treatment.

Patient/Parent/Legal Guardian/Representative Signature

Parent/Legal Guardian/Representative Name