Springwood Dental Associates
Consent Form

I give Dr's Paul and Christian Bowman or Anthony Lupinetti consent to use local anesthetic as needed.

I hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of therapy and administer any medications necessary and agreed upon.

I am aware of the possibility of complications resulting from the use of dental instruments. materials, medications, and injections, including but not limited to: swelling, bleeding, pain, infection, numbness and tingling in the lip, tongue, chin, gums, cheeks and teeth which may be transient, but on infrequent occasions, may be permanent, reactions to infections, changes in occlusion (bite), jaw muscle cramps and spasms, tempromandibular (jaw) joint difficulty, loosening of teeth, referred pain to the ear, neck and head, nausea, vomiting, increased heart rate, allergic reactions and delayed healing.

Medications prescribed for infection and discomfort may cause drowsiness and lack of awareness and coordination, which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs. I understand that it is not advisable to operate any vehicle or engage in any activity, which requires me to be alert while taking such medication. In addition, I understand that prescribed medications may interfere with the action of drugs I am currently taking.

Springwood Dental Associates only uses composite resin fillings (tooth colored fillings). On children we commonly recommend sealants, and give fluoride treatments as part of the routine exam and cleaning. Most insurance policies have coverage limitations on these procedures. Patients will be responsible for any balance incurred as a result of a coverage limitation, co-insurance or deductible.

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the Dentists and staff of Springwood Dental to help determine appropriate dental treatment. This information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status or life changes. I will not hold my Dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (or Responsible Party): _____
Date: _____