

**CONSENT FOR ADMINISTRATION OF
LOCAL ANESTHETIC FOR DENTAL PROCEDURE(S)**

Patient Name: _____
Birthdate: _____

BP: _____
Pulse: _____

Please read the following regarding the use of local anesthetic in your dental care, and after all of your questions have been answered by the dentist and/or his office staff regarding this subject, please sign and date this page as provided below.

Topical anesthetics are applied to mouth tissues with a swab to prevent pain on the surface level. Your dentist may use a topical anesthetic to numb an area in preparation for administering an injectable local anesthetic.

Injectable local anesthetics prevent pain in a specific area of your mouth during treatment by blocking the nerves that sense or transmit pain and numbing mouth tissues. They cause the temporary numbness often referred to as a "fat lip" feeling. Injectable anesthetics may be used in such procedures as filling cavities, preparing teeth for crowns or treating periodontal (gum) disease. Most dental procedures require up to two, and occasionally more, injections of a local anesthetic. Also, most anesthetic solutions are bitter, and this will be tasted if there is leakage from the injection site(s).

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

I understand that although local anesthesia is extremely safe, some rare or more serious complications may occur secondary to the administration of local anesthesia.

I understand that the most common complications that may occur while the administering of local anesthetic in dentistry include, but are not limited to, ecchymosis and analgesia, evidenced by pain, swelling and/or bruising. The rare and more serious complications are paresthesia or permanent anesthesia (permanent numbness or abnormal sensation), and in rare cases life threatening conditions.

I understand more than one injection may be needed to achieve a satisfactory or desired results for treatment purposes.

I understand that dentistry is not an exact science and that dental practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my self or my minor child. I have had full opportunity to discuss and ask questions regarding my treatment, and all questions have been answered to my satisfaction.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient