R. Renan
Williams DDS

General Dentistry

5104 Eldorado Dr.
North Richland Hills, TX 76180

Informed Consent of General Dentistry

1. **EXAMINATION AND X-RAYS**

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

Initials: __________

2. **DRUGS, MEDICATION, AND LOCAL ANESTHETIC**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergy reaction). I have informed the dentist of any known allergies. They may cause drowsiness, lack of awareness, and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Initials: __________

3. **CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials: __________

4. **TEMPOROMANDIBULAR JOINT DISFUNCTION (TMD)**

I understand that popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

Initials: __________

5. **Photo Release**

I authorize Dr. Williams to take photographs/videos of my face, jaw and teeth, before, during, and after treatment. I consent for the photographs to be used for the following: dental records, dental research, dental education including lectures, seminars, demonstrations, professional publications such as journals or books, marketing material, patient education and social media. I further understand that if the photographs/ videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise for the use of these photos.

Initials: __________

Signature: ___________________________________ Date: __________________