Acknowledgement of Consent for Laser Treatment

This authorization and informed consent is given of my own free will after the doctor has explained to me the foreseeable dental and medical risks involved and discussed below. I understand the purpose of this treatment is to treat and possibly correct my diseased tooth and/or tissues in my mouth.

1. Use of a laser for dental treatment (hard and/or soft tissue and root canal) is a very safe and predictable form of treatment. Laser energy is not ionizing radiation (i.e. x-rays). It is photo-thermal (produces heat).
2. Safety glasses are worn to protect the eyes from any unforeseen effects. These glasses are specific to the type of laser being used.
3. Water and air are used as cooling devices for the heat generated.
4. As with any form of dental treatment involving hard and soft tissue treatments, the following can occur:

INFECTION – In rare instances, an infection can occur.

BLEEDING – Slow oozing of blood is NORMAL after certain surgical procedures but can usually be controlled due to the laser's capacity for hemostasis (stopping the flow of blood).

ANESTHESIA – Minimal anesthesia is required for treatment with a laser.

BENEFITS OF LASER TREATMENT - You will find that more often than not, anesthesia, other than topically applied, will not be required. Postoperative pain will be reduced. Healing time will be reduced. Procedures will be completed at a much faster rate.

OTHER PROBLEMS – As with any dental procedure, there are minor problems not mentioned that can occur but be assured that you are receiving the highest technology dentistry offers.

Please initial below before signing to acknowledge your consent.

I consent to photography, filming, recording, x-rays and/or digital imaging of the procedures to be performed for the purpose of dental education and the advancement of dentistry. _____

I certify that I have read and fully understand the above authorization and informed consent and the information referred to above and that all my questions have been answered to my satisfaction. _____

No guarantee of success has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I understand and appreciate that the intention of the doctor is to relieve me of pain and suffering or eliminate a potential pathologic condition and the benefits of the proposed treatment far outweigh the possible complications mentioned above. By signing below you acknowledge that you have read this document, understand the information presented and have had all of your questions answered satisfactorily.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____