EAST SIDE HEALTH DISTRICT
PREVENTIVE HEALTH & EDUCATION SERVICES

638 N 20th Street, East St Louis, IL 62205

Patient's Name:___________________________ Birthdate:________________ Chart#_______________

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at East Side Health District. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

ALLERGIES/MEDICATION, I have informed the Dentist of any known allergies I may have. 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 allergic reaction). They may cause drowsiness and 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 or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain, or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Do you have any allergic reaction to any of the following:

___ Epinephrine ___ Any Local Anesthetic ___ Penicillin ___ Nickel (metals) ___ Acrylic

CONSENT. I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure. I also understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

Patient Signature:____ Date:_____________

Print Name:_______________________________________

Parent/Guardian Signature:______________________________________ Date:_____________

Print Name:_______________________________________