

Vogel Dental Inc.
777 North 500 West, #201
Provo, Utah 84601
(801) 374-8244

Consent for Dental Treatment 1.0 - Please read thoroughly, ask questions if needed

Health Questionnaire Acknowledgment and Consent to Proceed: I certify that the answers to the health questions are accurate and correct of the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Vogel and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of a minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, an/or pharmaceutical agent(s) including those related to restorative, palliative, therapeutic or surgical treatments.

I understand the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated or swallowed. This situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of subsequent and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and if necessary I have been given the opportunity to ask questions.

Clinical photo consent: I give permission for clinical photos, video and radiographs to be taken before, during and after my treatment. I give permission for these to be used by Dr. Vogel for educational purposes. I will not ask for any monetary return for their use. All use of these items will be kept strictly anonymous and no personal information will be released in conjunction with their use.

ERIC G. VOGEL DDS * MICHAEL MERKLEY DDS * TOM DAVENPORT