Benjamin Godder, DMD, PC
115 E. 57 Street, Suite 1520
New York, New York 10022
(212) 750-3470

Consent to Dental Treatment

Patient's Name ______________________________ **Date** :________________

I hereby authorize Dr. Benjamin Godder D.M.D. P.C. and his associates to perform on me the following dental operations and /or procedures, listed on the Treatment Plan.

If any unforeseen condition arises in the course of these authorized operations and /or procedures which necessitate procedures different from or in addition to those set out above, I further authorize the Doctor to perform these procedures/operations.

I consent to this plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.

I am informed and fully understand that there is, in any type of treatment, the possibility of certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling and bruising, discomfort, loss or loosening of dental restorations. Less common complications can include infection, loss or injury of adjacent teeth and soft tissues, nerve disturbances (e. g. numbness in the mouth and lips tissues), jaw fractures, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug responses, cardiac arrest, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I understand that I am responsible for all fees regardless of insurance coverage. I also understand that as treatment progresses the fees may have to be adjusted, but that I will be informed of these adjustments and how they will affect my payment plan. In the event that my payments are not received within 30 days of their due date, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees.

Signature of Patient or Guardian: ______________________ **Date:** ___________

Signature of Witness: ______________________________ **Date:** ___________