PAOLUCCI FAMILY DENTISTS, INC.

931 SMITH STREET

PROVIDENCE, RHODE ISLAND 02908

INFORMED CONSENT FOR TREATMENT

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure(s), alternative treatment(s) or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is every important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post retreatment instructions, referrals to other dentists and specialists and to return for scheduled appointments. If you fail to follow the advice of your dentist, then you may increase the chances of poor outcome.

Please read the items below and sign/date at the bottom of the form.

1. **Treatment to be provided:**
   I understand that during my course of treatment the care provided may include examinations, preventative services, restoration, crowns, bridges, implants and other dental and surgical procedures. During the performance of these procedures, there is a small risk of damage to adjacent teeth, crowns or other anatomical structures.

2. **Drugs and Medications:**
   I understand that antibiotics, analgesics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

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 examination, the most common being root canal therapy following routine restorative procedures.

By signing below, you affirm that you understand and agree to the above statement.

Name: _____

Signature: _____ Date: _____