Patient Name_____

PERIO, PLLC
Dr. John M. Remien DDS, MS
3817 Stephens Ave.
Missoula, MT 59801

CONSENT FOR DENTAL PROCEDURE

John M. Remien, DDS, MS or staff has explained to me the following procedure or treatment to be undertaken:

I am aware that alternative procedures for treatment may be available. I am aware that I may elect NOT to proceed with the recommended treatment. I acknowledge that no guarantee or warranty has been made as to the results of any of the above-recommended choices.

RISKS RELATED TO THE PROCEDURE: Risks related to the above treatment might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries, or associated muscle spasm, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of the gum upon healing (which could result in elongation of and/or greater spaces between some teeth). Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness or discoloration at the site of injection of anesthetics.

Additionally, Dr. John Remien or staff has offered me a more detailed explanation of this recommended treatment, if I so desire. I am fully satisfied with the description and information given, and all of my questions have been satisfactorily answered.

Therefore, I give my consent to the above-recommended treatment.

Patient's Signature (or Parent/Guardian) _____Date_____