

BRIGHT SMILES, LLC  
Dr. Shunda Thompson  
907 Pavilion Court  
McDonough, GA 30253  
678-583-8536

## GENERAL CONSENT FOR TREATMENT

My signature confirms that I have been informed by Dr. Shunda Thompson and/or persons on her staff regarding my oral treatment needs:

- Diagnosis
- Treatment and alternatives
- Advantages and Disadvantage of each alternative
- Risks, if present
- Result(s) of doing nothing at all regarding my oral treatment needs

The following treatment and work to be done as indicated below was agreed upon:

*Initials:*

**TOOTH RESTORATION (FILLING):**

\_\_\_\_ Tooth-Color (composite) restoration  
\_\_\_\_ Amalgam (silver) restoration

**DENTURES (REMOVABLE PROSTHODONTICS):**

\_\_\_\_ Complete Dentures  
\_\_\_\_ Immediate Temporary Dentures  
\_\_\_\_ Removable Partial Dentures

**PERIODONTAL TREATMENT:**

\_\_\_\_ Debridement (Soft Tissue Management – STM)  
\_\_\_\_ Root Planning and Scaling  
\_\_\_\_ Periodontal Maintenance every \_\_\_\_ Months  
\_\_\_\_ Cracked Tooth Syndrome Treatment

*Initials:*

\_\_\_\_ CROWNS, BRIDGES, STEEL CROWNS  
\_\_\_\_ ENAMEL RESHAPING  
\_\_\_\_ ENDODONTIC TREATMENT  
(Root Canal Therapy RCT)  
\_\_\_\_ PULPOTOMY, INDIRECT PULP CAP  
\_\_\_\_ NITROUS OXIDE/LAUGHING GAS  
\_\_\_\_ TOOTH SEALANTS  
\_\_\_\_ TEETH WHITENING  
\_\_\_\_ SPACE MAINTAINER  
\_\_\_\_ TOOTH EXTRACTION  
\_\_\_\_ OTHER: \_\_\_\_\_

I understand that antibiotics (interferes with effectiveness of contraceptives), analgesics and other medications can cause allergic reactions.

By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information and that all of my questions have been answered fully and satisfactorily. I also understand the fees involved. Finally, I understand the possibility of an unsuccessful outcome in the event of inadequate follow-up with the dentist and hygienist and inadequate home care.

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 examinations. For example, root canal therapy following routine restorative procedures.

Understanding this, I give my permission and I hereby authorize the above-named dentist to make any/all changes and additions as necessary and to provide the above mentioned treatment and service(s).

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Staff Person: \_\_\_\_\_ Date: \_\_\_\_\_