

Derrick Hampton, D.M.D., P.C.  
NAME OF PRACTICE

**Consent Form**

In the case that my dentist has determined certain procedures may be beneficial in the diagnosis and treatment of my condition, I authorize and direct Dr. Derrick Hampton, or assistants of his choice to perform such procedures, including the arranging for whatever incidental procedures and/or additional services, involving anesthesia, radiology, pathology and the like, as he may deem advisable for my well being. Any tissue or member severed in any surgery or procedure may be disposed of in the best discretion of the dentist.

I understand that Dr. Derrick Hampton maintains personnel and facilities to assist in his performance of various dental procedures, special diagnostic and therapeutic procedures. All involve risks or complications, serious injury or even death, from both known and unknown causes. I am well aware that, except in case of emergency or exceptional circumstances, these procedures are not performed unless the patient has had an opportunity to discuss them with the dentist. I further understand that many factors contribute to the success of dental treatment and cannot be determined in advance; such as my resistance to infection, the location and shape of roots, etc. I further understand that during and following treatment, I am to contact the doctor's office if I have any additional questions. I understand that it is very important that I follow the doctor's instructions. I also understand that each patient has the right to consent or to refuse any proposed surgery or procedure. I understand that if I refuse treatment, I will sign a waiver and release Dr. Derrick Hampton, his associates, and his staff from any fault that may arise from my decision not to seek said treatment. I further understand that due to individual patient differences there exists a risk of failure, relapse, selective retreatment or worsening of my present condition despite the best of efforts. I understand that long term success is directly related to the continued performance of mechanical plaque removal (tooth brushing and flossing) and my availability for periodic maintenance visits. I understand that my failure to follow the dentist's direction for follow-up care and visits will jeopardize the success of the treatment. I also understand that there can be adverse reactions to dental anesthetic and materials used for treatment, including but not limited to : allergic reaction, hypo and hypertension, parasthesia, retained anesthesia, and death.

My signature below constitutes my acknowledgment (1) that I have read and agree to the foregoing, (2) that the proposed surgery (s) or procedure(s) has/have been satisfactorily explained to me, and I have all the information I desire; (3) that no guarantees or assurances have been given to anyone as to the results that may be obtained; and (4) that I hereby give my unqualified authorization and consent therefore

Patients Signature \_\_\_\_\_ Date/Time \_\_\_\_\_

Guardian Signature (if appropriate) \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_