Victorian Village
DENTAL CARE

Victorian Village Dental Care, Rolando M. Martinez, D.M.D., Inc.
1020 Dennison Ave #100
Columbus, OH 43201
(614) 298-1543

Patients Name_____
LAST FIRST INITIAL

I hereby authorize Dr. Rolando M. Martinez and whomever he may use as his assistants, to perform upon me the following operation and/or procedures:

I request and authorize him to do whatever he deems advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatment and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages, and disadvantages of the alternative treatment.

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 there is a slight element of risk inherent in the administration of any drug and anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, aspiration, thrombophlebitis (e.g. irritation and swelling of the vein), pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling, bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which may require extensive surgery for removal.

I realize that in spite of the possible complications and risks my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete medical and personal history as possible including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions about my medical condition, contemplated alternative treatment and procedures, and the risk of potential complications of the contemplated and alternative treatments and procedures prior to signing this form.

Appointment Policy

Failed or canceled appointments cause a waste of valuable professional time and deprive others of treatment. Anyone 15 minutes late for his/her appointment may be rescheduled and it will be considered a broken appointment. It will be your responsibility to keep track of your appointment.

Patients who do NOT cancel within 24 hours of their appointment or fail to show will be charged a fee of $70 for an appointment with the hygienist and $68 minimum for appointments with Dr. Martinez.

If a patient misses (2) appointments without giving a 24-hour notice, we will no longer provide dental services for the patient. It will be your responsibility to find another dentist for your dental needs.

Patient or Guardian's Signature_____ Date_____

Dentist's Signature_____ Date_____