ARIZONA CENTER
FOR LASER DENTISTRY

Consent for Laser Treatment

Your Dental Team at Arizona Center for Laser Dentistry is committed to providing a superior level of dental care to you, your family, and your friends. This commitment requires staying current on all the latest science, research, and technology available to provide the highest level of care possible.

BENEFITS OF LASER TREATMENT - Postoperative pain will be reduced. Healing time will be reduced. The purpose of this treatment is to improve my oral and periodontal health. Procedures will be completed at a much faster rate.

1. Use of a laser for dental treatment (hard and/or soft tissue and root canal) is a very safe and predictable form of treatment. Laser energy is not ionizing radiation (i.e. x-rays). It is photo-thermal (produces heat).
2. Minimal anesthesia is required for treatment with a laser.
3. Lasers are sterile, which means there is less chance for an infection.
4. Lasers are extremely precise, so less healthy tissue must be removed
5. Safety glasses are worn to protect the eyes from any unforeseen effects. These glasses are specific to the type of laser being used.
6. Water and air are used as cooling devices for the heat generated.
7. As with any dental procedure, there are minor problems not mentioned that can occur but be assured that you are receiving the highest technology dentistry offers.

Please initial below before signing to acknowledge your consent.

I understand the purpose of this treatment is to treat and possibly correct my diseased tooth and/or tissues in my mouth. _____

I certify that I have read and fully understand the above authorization and informed consent and the information referred to above and that all my questions have been answered to my satisfaction. _____

I understand that I may decline treatment at any time and that my dentist may also discontinue my treatment if it is not detrimental to my oral health. _____

No guarantee of success has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I understand and appreciate that the intention of the doctor is to relieve me of pain and suffering or eliminate a potential pathologic condition and the benefits of the proposed treatment far outweigh the possible complications mentioned above. By signing below, you acknowledge that you have read this document, understand the information presented and have had all of your questions answered satisfactorily.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

7900 E. Thompson Peak • Suite 101 • Scottsdale • AZ • 85255 • P (480) 990-1905 • F (480) 990-2311 • www.drdivito.com