Informed Consent

General Dentistry

Patient Name: _____ Chart #: _____

All Patients complete 1 through 4 below and 5 through 14 as needed

1. **EXAMINATION AND X-RAYS**
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

Initials_____ Date _____

2. **DRUGS, MEDICATION AND SEDATION**
I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. The medication may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree to not operate and vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of any condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

Initials_____ Date_____

3. **CHANGES IN TREATMENT PLAN**
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 examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials _____ Date _____

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**
I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

Initials _____Date _____

5. **DENTAL PROPHYLAXIS (CLEANING)**
I understand the treatment is preventive in nature, intended for patients with healthy gums and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

Initials _____ Date _____

6. **FILLINGS**
I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

Initials _____Date _____

7. **REMOVAL OF TEETH & RIDGE PRESERVATION**
Alternatives to tooth removal have been explained to me (root canal therapy, crown and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Pasathesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. Ridge preservation procedure has been explained to me. I understand ridge preservation limits the loss of bone following extraction but does not prevent it. I understand the use of bone graft materials (including human bone, animal bone, and synthetic bone) with or without membranes of different natures (animal and synthetic). I understand the risk of infection following ridge preservation and membrane exposure which might require removal and replacement of the grant. I understand with ridge preservation, the healing of the extraction site will be slower which might extend the total time of treatment. I understand even with the ridge preservation procedure, I might need additional bone grafting or sinus lifting prior to implant placement.

Initials _____ Date _____

8. **CROWNS, BRIDGES, VENEERS AND BONDING**
a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth, I further understand that I may be wearing a temporary crown, which may come off easily and that I must be careful to ensure that they are kept on until the final crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge or veneer (including shape, fit size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for final cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying final cementation.

Initials _____ Date _____

b. I am electing to use high noble or ceramic instead of base metal in my crown and bridge restorations.

Initials _____ Date _____

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

Initials _____ Date _____

9. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

Initials _____ Date _____

10. ENDODONTIC TREATMENT (ROOT CANAL TREATMENT)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture in one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Initials _____ Date _____

11. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease and preterm labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery and/or extractions. I understand the success of any treatment depend in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours following treatment. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contracted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

Initials _____ Date _____

12. IMPLANTS

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity and this numbness may be of a temporary or rarely permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

Initials _____ Date _____

13. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with each individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide Peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has known risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

Initials _____ Date _____

14. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, dizziness and headache. I understand that nitrous oxide use in not indicated if I am pregnant.

Initials _____ Date _____

I understand that dentistry in not an exact science and those therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Patient or Guardian Signature_____ Date_____

Doctor Name and Signature_____Date_____

Treatment Coordinator Name and Signature: _____ Date: _____