

GENERAL DENTISTRY INFORMED CONSENT

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____, Bridges _____, Crowns _____, Extractions _____, Root Canal _____, Exams & X-Ray _____, Other _____.

(Initials _____)

2. DRUG, MEDICATIONS, AND SEDATION

I have been informed and understand that antibiotics, analgesics and other medication can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction) and they can cause pain thrombophlebitis (inflammation of a vein) from intravenous and intramuscular injections, injury to and stiffening of neck and facial muscles. They may cause drowsiness and lack of awareness and coordination which can be increased by use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effect 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 medication prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. On occasion, you may experience prolonged numbness (paraesthesia) of lower lip skin and/ or tongue after the injection of a local anesthetic. This should be temporary and normal sensation should come back.

(Initials _____)

3. CHANGE IN TREATMENT PLAN

I understand that during treatment in may be necessary to change or all 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 _____)

4. REMOVAL OF TEETH

Alternative to removal have been explained to me (root canal therapy, crowns, 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, loss of feeling in my teeth, lips, tongue and surrounding tissue (paraesthesia) that can last for an indefinite period of time or fracture jaw. I understand I may need further treatment by a specialist or even hospitalization if complication arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

5. CROWNS, BRIDGES, CAPS, VENEERS, AND BONDING

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 temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (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 further 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.

(Initials _____)

6. 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 applications 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. 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.

(Initials _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment and that occasionally metal objects are cemented into the tooth or extend through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials _____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/ or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

(Initials _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee on assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist nor is responsible for my dentist treatment. I acknowledge the receipt of and understand post-operative instruction and have been given an appointment date to return.

Signature : _____

Date: _____

Doctor: _____

Witness: _____