

INFORMED CONSENT PATIENT NAME: _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings [], Bridges [], Crowns [], X-rays [], Extractions [], Impacted Teeth Removed [], Root Canals [], Dentures [], Partials [], Periodontics [], Exam [], Cleaning [], Other []

2. DRUG AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes 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 under paragraph #3. I understand removing teeth does not always remove all the infection, if present, it may be necessary to have further treatment. I understand the risk 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 (Parasthesia) that can last for an indefinite period of time (days of months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

5. ANASTHESIA

I realize the risks involved in receiving a local anesthetic, some which are: partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness.

6. CROWNS BRIDGES AND CAPS

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, and that if the permanent crown(s) placed, permanent serious damage or loss of the tooth/teeth involved my ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

7. DENTURES- COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage and relining due to tissue and bone change.

8. ENDODONTIC TREATMENT (ROOT CANAL)

I realize that 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 in the tooth or extend through the root which does not necessarily affect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

9. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. **Initials** _____

I hereby request and authorize the Dentists and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues as explained above.

The effect and nature of the proceeding to be performed and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure, which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment, which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia), fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: _____

Date: _____