GENERAL DENTISTRY INFORMED CONSENT

Patient Name: _____

1. WORK TO BE DONE: I understand that I am having the following work done: X-rays____, Exam _____, Fillings___, Crowns ____,Bridges ____, Extractions ____, Root Canal ____, Dentures _____, Other ___.

Initials _____

2.DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics and other medications can cause Allergic reactions causing redness and swelling of tissue, pain, itching, vomiting and /or anaphylactic shock. Rarely,temporary or permanent nerve injury may result from an injection. **Initials _____**

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. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to any and all changes and additions

Initials _____

4. REMOVAL OF TEETH:: alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery) and I authorize the Dentist to remove the following teeth _____ and any 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, such as pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parathesia) that can last for an indefinite period of time or fractured jaw, I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Initials _____

5. CROWNS, BRIDGES AND CAPS, (Including SSC): 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 the final opportunity to make changes in may new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Initial _____

6. 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 root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontics files and reamers are very fine instruments and stresses vented in their manufacture 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 effort to save it.

Initials _____

7. PERIODONTAL LOSS (TISSUE AND BONE): I understand that I have a serious periodontal condition causing gum inflammation and bone loss and that it can lead to the 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 effect on my periodontal condition.

Initials_____

8. FILLINGS: I understand that care must be exercised in chewing on fillings, specialist during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filings. If the sensitivity continues, I understand that a root canal may be needed, even through the tooth may not have hurt prior to the filling being done.

Initials _____

9. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to delays of more than 30 days, there will be additional charges.

Initials _____

I understand that dentistry 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 dental treatment, which I have requested and authorized. I understand that regardless of any insurance coverage I may have. I am responsible for payment of dental fees. I agree to pay any attorney fees, collections fees, or court costs that may incurred to satisfy this obligation.

Signature of Patient or Guardian _____ **Date:**_____

Signature of Doctor: _____ **Date:** _____