Informed Consent

I have read the HIPAA Privacy Notice and the Dental Materials Fact Sheet and understand I may receive a copy of these documents upon request.

Name_____

Patient/Guardian Signature_____ Date: _____

1. PROPOSED TREATMENT

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2. LOCAL ANESTHETICS AND OTHER DRUGS
I understand that local anesthetics, antibiotics, analgesics and other medications can cause bruising, prolonged numbness, nerve damage, vomiting, and allergic reactions resulting in redness, swelling, itching and/or anaphylatic shock (severe allergic reaction). **Initial** _____

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. **Initial** _____

4. REMOVAL OF TEETH
Alternatives 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 _____. I understand removing teeth does not always remove all the infection 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 (parasthesia) that can last for an indefinite period of time, muscle stiffness or fractured jaw or retained root tip. I understand 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. **Initial** _____

5. PROPHYLAXIS AND ROOT PLANING
I understand that routine cleaning (prophy) or even deep cleaning (root planing) is necessary to inhibit gum disease. Sensitive teeth and gums and loosening of poor filling may result from treatment. Alternatives may include gum surgery or extraction. **Initial** _____

6. FILLINGS
I understand that only ADA accepted amalgam and composite filling materials are used. Fillings may break, discolor, or fall out and may make tooth sensitive to temperature change, prone to fracture or abscess. Alternatives may include extraction or crown. **Initial** _____

7. ROOT CANAL
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur including root perforation, broken file in canal, undiagnosed root fracture, unfilled accessory canals and extended fill beyond root tip. Occasionally, additional surgical procedures may be necessary following root canal treatment such as apicoectomy or extraction. The alternative may include extraction. **Initial** _____

8. CROWN AND BRIDGE
I realize the final opportunity to make changes in my new crown or bridge (including shape, fit, size, color) will be before cementation. I understand that a crown may come off and require recementation and that the porcelain portion may fracture. The tooth may also abscess and require further treatment and future decay may require retreatment for a crown. Also, food particles may become lodged under a bridge. Alternatives include a filling if feasible or extraction. Alternatives for a bridge include partial denture, implants or leaving spaces. **Initial** _____

9. DENTURE COMPLETE OR PARTIAL
I realize that full or partial dentures should be removed nightly. The problems of wearing dentures have been explained to me including looseness, soreness and possible breakage. I understand that dentures may require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. Also, metal clasps may be visible and anchor teeth may loosen or decay. Alternatives include bridgework if feasible or leaving spaces. **Initial** _____

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 authorize.

Signature_____Date_____

Doctor

Date