BASIC INFORMED CONSENT FOR GENERAL DENTISTRY

Patient Name:_____ Chart #:_____ Office:_____ Birthdate: _____

All patients complete 1 thru 4 below and 5 thru 13 as needed.

1. EXAMINATIONS 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. Some of the treatment like taking x-rays, placement of the restorations, polishing, etc. may be performed by a trained assistant or a Restorative Functions dental assistant.

(Initials _____)

2. DRUGS, MEDICATION AND SEDATION:
I have been informed and understand that anesthetics, antibiotics, analgesics or other medications can have reactions including 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. They 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 not to operate any 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 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 my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). It is critical that I tell my dentist of all medications currently being taken, including OTC and supplements since all medications have the potential for accompanying risks, side effects, and drug interactions. The written informed consent, in the case of a minor, shall include, but not be limited to, the following information: Administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of clinician, the age and health of the patient and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment, and consult with your dentist or pediatrician as needed.

(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, 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. 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, the cost of which is my responsibility and I may be referred to a specialist for treatment.

(Initials _____)

5. DENTAL PROPHYLAXIS (CLEANING):
I understand the treatment is preventative 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 _____)

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 and that adjustment/s may be necessary. (Initials _____)

This signature line applies to California only:

I, _____ acknowledge I have received from Dr. _____ a copy of the Dental Materials Fact Sheet dated October 2001.

(Initials _____)

7. REMOVAL OF TEETH:
Alternatives, if any, to 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 in pain, tooth breakage, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) 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.

(Initials _____)

8. CROWNS, BRIDGES, 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 crown/s, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crown/s 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 permanent cementation as directed by the dentist. Excessive delays may allow for decay, tooth movement, tooth breakage, 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 permanent cementation.

(Initials _____)

9. 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, vomiting, dizziness and headache. I understand that nitrous oxide use is not recommended if I am pregnant.

(Initials _____)

10. DENTURES – COMPLETE OR PARTIAL:
I realize that full or partial dentures are artificial, removable and constructed of plastic, metal, and/or porcelain, which require regular adjustment/s and/or reline/s. 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 denture (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 _____)

11. ENDODONTIC TREATMENT (ROOT CANAL):
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 is one of the main reasons root canals fail. Since teeth with root canal treatments are more brittle than other teeth, they are more prone to breakage and require a crown 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 _____)

12. PERIODONTAL TREATMENT:
I understand that I have a serious condition causing gum inflammation, infection and/or bone loss, which can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term 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 depends 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. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials _____)

13. 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 further treatment and even 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 _____)

14. TOOTH WHITENING OR 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 the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea, red wine 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 or other 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 unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _____)

15. DENTAL BENEFITS:
I understand that my insurance benefits may not provide for ideal or comprehensive dental care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the dentist's recommendation of optimal dental treatment.

(Initials _____)

Acknowledgment:

- I have received, discussed and understand my proposed treatment, alternate treatment plan options, and their associated risks with the dental team and have had all my questions fully answered.
- I understand that each dentist is an individual clinician and the only one responsible for the dental care rendered to me, and that no other dentist or corporate entity is responsible for my dental treatment.
- I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees or promises been made to me concerning the treatment, my recovery or any results from the treatment to be rendered to me. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.
- I understand that if any unexpected difficulties occur during treatment, I may be referred to another clinician or a specialist for further care at additional expense to me.

Patient/Parent/Guardian Signature: _____ Date: _____

Treating Dentist Signature: _____ Date: _____