Informed Consent

I understand that by signing below and initialing any of the following items, I am requesting and authorizing the procedure(s) to be performed and I have read and understand the possible risks and complications of the procedure(s).

Initials_____

1) X-Rays & Examination

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken of my teeth, I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant radiation exposure poses a serious threat to the life and health of my unborn child. **Pregnant women are required to have a medical release from their Medical Doctor prior to X-rays and Dental treatment.**

Initials_____

2) Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand there may be unforeseen changes that can occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/or all changes and additions as necessary.

Initials_____

3) Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can include redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

Initials_____

4) Removal of Teeth

Alternatives for tooth 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 others necessary for reasons outlined in paragraph #2. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the following risks associated with having teeth removed: pain, spread of infection, dry socket, swelling, fractured jaw, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time. I understand I may need further treatment by a specialist, the cost of which is my responsibility.

Initials_____

5) Crowns and Bridges.

I understand that I may be wearing temporary crowns, and that I must be careful to ensure they are not removed until the permanent crowns are delivered. I understand that sometimes it is not possible to match the color of artificial teeth to that of my natural teeth. I realize the last opportunity to make changes to my crown, cap, or bridge is before permanent cementation. I must return to the dentist for permanent cementation within 20 days of tooth preparation. Extended delays between the time of tooth preparation and crown cementation may cause tooth movement, accumulation of bacteria, and/or infection of tooth structure and the surrounding tissues. It may then be necessary to remake the crown, cap, or bridge, and, in some cases, remove the tooth or teeth. I understand there will be additional charges for remakes due to my delaying permanent cementation. I also understand that after placement of a temporary or permanent crown, my tooth may be temporarily sore or uncomfortable. Occasionally the pulp (nerve tissue) may be irritated by the preparation process or from prior trauma or decay. This may make my tooth extremely sensitive. I understand that, if this persists, root canal therapy may be necessary at an additional charge. I also understand that in the event I have an existing partial denture and am having a crown placed on any tooth immediately adjacent to the denture, my existing partial may not fit as it did prior to crown placement. I understand that although every effort will be made to adjust my partial, such adjustments are not always successful. In the event that appropriate adjustment cannot be made, I acknowledge that after crown placement I may need a new partial denture at an additional charge.

Initials_____

6) Root Canals/Endodontic Treatment

I understand there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment: root canal filling material can extend through the tooth (which will not necessarily affect the success of the treatment) and endodontic files and reamers can separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment.

Initials_____

7) Periodontal Loss

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

Initials_____

8) Fillings

I understand that care must be exercised in chewing with fillings, especially 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 filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being placed.

Initials_____

9) Dentures

I understand wearing dentures is difficult. Sore spots, altered speech, and eating difficulties are common. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. (Initials_____) 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 my delays of more than 30 days, there will be additional charges.

Initials_____

I understand that there has been no guarantee or assurance made by anyone in regard to the dental treatment I have authorized. I also acknowledge that I am ultimately responsible for all dental fee payments regardless of any dental insurance coverage.

Signature of Patient_____ Date_____

Signature of Doctor_____ Date_____