GENERAL DENTISTRY NAME_____
INFORMED CONSENT

1. Work to be done

I understand that I am having the following work done: Fillings____,Bridge_____,Crown_____,Extraction_____ impacted teeth remove____, Root Canal_____,Dentures_____, Other_____ Initials_____

2. Drugs and Medications

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

3. Changes in treatment plan

I understand that during treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were not discovered during the examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any /all changes and additions and necessary Initials_____

4. Removal of Teeth

Alternatives to removal have been explained to me(root canal therapy, crowns , periodontal surgery, etc.)and I authorize the Dentist to remove the following teeth_____ and any others necessary for the 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 pain, swelling, spread of infections, dry socket, loss of feeling in my teeth, lips tongue ,and surrounding tissue(apicoectomy) 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 the following treatment, the cost of which is my responsibility.

Initials_____

5. Crowns, Bridges and Caps

I understand that sometimes ir 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 permanents crowns are delivered. I realize the final opportunity to make changes in my new crown. bridge or cap(including shape ,fit, size, color) will be before cementation It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for teeth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remake due to my delaying permanent cementation.

Initials_____

6. Endodontic treatment (Root Canal Therapy)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasional root canal filling material may extend through the root which does not necessarily effect the success if the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite all effort to save it. Initials_____

7.Periodontal Loss (Tissue & Bone)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that is 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 procedures ,ay have a future effect on my periodontal condition. Initials_____

8. Fillings

I understand that care must be exercised in chewing on 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 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 extraction) may be painful. Immediate dentures may require considerable adjustment 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 will be a additional charges.

Initials_____

I understand that dentistry is not an exact science and that therefore reputable practitioner 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 each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that no other dentist or Dental Group is responsible for my dental treatment

I hereby authorize any of the doctors or dental auxiliaries of Family Dentistry to proceed with and perform the dental restorations and treatment as explained to me. I understand that this is only an estimate and subject to modification depending on unforseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have. I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees or court costs that may be incurred to satisfy this obligation.

Should any dispute arise over dental services provided to me, that is whether any dental services rendered was allegedly unnecessary, unauthorized or was improperly, negligently or incompetently performed, said dispute will be submitted to Peer Review by the local component of The American Dental Association. The decision of Peer Review shall be binding on both parties. I have read, understood and agreed to the above.

Signature_____Date_____

Witness_____