



GENERAL DENTISTRY INFORMED CONSENT

1. **EXAMINATION AND X-RAYS** - I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. (Initials _____)
2. **DRUGS, MEDICATIONS, AND SEDATION** - I have been informed and 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 (severe allergic reaction). They may cause drowsiness and 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 until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that the 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 of oral contraception. (Initials _____)
3. **CHANGES IN TREATMENT PLAN** - I understand that during treatment it may be necessary to change or add procedures (patient will be informed about Treatment Plan changes) 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, after having been informed and in agreement with the changes. (Initials _____)
4. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)** - I understand that symptoms of 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, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. (Initials _____)
5. **FILLINGS** - 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. (Initials _____)
6. **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 _____ and any other 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 pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. 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. (Initials _____)
7. **CROWNS, BRIDGES, CAPS, 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 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 my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. I further understand that my gingiva (gums) will be sore until healing time has elapsed and that during this healing time my gingiva around the tooth being capped will shrink (recession), sometimes making the tooth look longer than the natural tooth. (Initials _____)
8. **DENTURES-COMplete OR PARTIAL** - I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these 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 "tooth in wax" try-in visit. 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. (Initials _____)
9. **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 metal objects are cemented in the tooth or extended through the root which do not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicectomy). (Initials _____)
10. **PERIODONTAL LOSS (TISSUE AND BONE)** - I understand that I have a serious condition, causing gum and bone inflammation 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 procedures may have a future adverse effect on my periodontal condition. (Initials _____)

I understand that dentistry is not an exact science and 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.

Patient/Guardian/Parent Signature: _____ Relation to Patient _____ Date _____

Doctor Signature _____ Date _____

6 MONTH RECALL

Patient/Guardian/Parent Signature: _____ Relation to Patient _____ Date _____

Doctor Signature _____ Witness (DA) _____