SMILE WEST SEATTLE

GENERAL DENTISTRY INFORMED CONSENT
(**INITIAL FIRST THREE ONLY**)

-1. TREATMENT PLAN: I understand that I am having x-rays and an examination done, in order to complete my visit (initials_____)

-2. DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting and/or anaphylactic shock (initials_____)

-3. CHANGES IN TREATMENT PLAN: I understand that during treatment it maybe necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any and all changes and additions as 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 of reason 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 (Parenthesis) 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 or following treatment, cost for which is my responsibility. (initials_____)

5. CROWNS, BRIDGES, AND CAPS: I understand that sometimes it is impossible to match the color of natural teeth exactly with artificial teeth . I further understand that I maybe wearing a temporary crown, 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 on my new crown or bridge will be before cementations. I understand that there may be additional charges for remaking a crown or bridge due to my delaying permanent cementation. (initials_____)

6. ENDODONTIC TREATMENT (ROOT CANAL)**:** I realize there is no guarantee that root canal therapy will save my tooth , and that complications can occur from treatment, and occasionally root canal filling material may extent through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stress on the instruments can cause them to separate during use. I also understand that the tooth may be lost in spite of all efforts to save it.

7. 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 procedure may have future adverse effect on my periodontal condition. (initials_____)

8. FILLINGS: I understand that care must be exercised when chewing during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnose may be required due to additional decay not detected on x-ray. I understand that sensitivity is common after affect 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 some common problems. Immediate dentures may require considerable adjusting 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 due to my delays there will be additional charges. (initials_____)

I understand that dentistry is not an exact science 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 authorized.

Signature of Patient_____ Date_____