**Palm Dental PLLC**

**General Inform Consent**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please initial by the proposed and accepted treatment:**

**\_\_\_\_\_1. Treatment to be rendered**

**I understand that I am having the following treatment performed:**

**\_\_\_X-Rays \_\_\_Prophylaxis \_\_\_Periodontal Procedures \_\_\_Fillings**

**\_\_\_Crown &Bridge \_\_\_Root Canals \_\_\_Extractions \_\_\_Dentures /Partial**

**\_\_\_\_\_2. Drugs and Medication**

**I understand that antibiotics, analgesics and other medications that I**

**may be prescribed can cause allergic reactions, including, but not limited**

**to swelling of tissue, pain, itching, vomiting and/or anaphylactic shock**

**death, a severe allergic reaction. I also understand that these**

**medications interfere with the effectiveness of contraceptives.**

**\_\_\_\_\_3. Changes in Treatment Plan**

**I understand that during treatment it may be necessary to change or add**

**procedures that were not discovered during my examination. For**

**example, if complications arise after a routine restoration procedure,**

**root canal therapy may be necessary. I give my permission to the**

**dentist to make any changes and/or additions as necessary, upon oral**

**or written explanation to me.**

**\_\_\_\_\_4.Removal of Teeth**

**I understand that procedures such as root canal therapy, placement of**

**crowns and periodontal surgery may be options for treatment.**

**However, I believe removing the infected tooth is the best option and I**

**authorize the dentist to remove the tooth listed below. I understand that**

**removing a tooth does not always remove all the infection, if present,**

**and it may be necessary to have further treatment. The risks involved in**

**having a tooth removed include, but are not limited to pain, swelling,**

**spread of infection, dry socket, fractured jaw, or loss of sensation in the**

**teeth, tongue and surrounding tissue (parenthesis). These risks can last**

**for an indefinite period of time. I also understand that I may need**

**further treatment by a specialist if complications arise during or following treatment**

**and I am responsible for the additional specialist fees. Tooth for removal \_\_\_\_\_\_\_\_\_.**

**\_\_\_\_\_5. Dentures**

**I understand that dentures may cause sore spots, altered speech and difficulty when**

**eating. I realize that receiving dentures immediately after extractions may be painful**

**and may require considerable adjustment and several relines. A permanent reline,**

**which is not included in the denture fee, will be necessary later.**

**I understand that the denture try-in appointment gives me the opportunity to approve**

**the cosmetic appearance of my dentures. I know it is my responsibility to look closely**

**at the size, shape, color, fullness and arrangement of my dentures. I understand**

**Continues on page 2**

**failure to keep any appointment may result in a poor fitting of my dentures. I realize**

**that I delay my appointment for more than 30 days, there will be additional charges**

**to my account. Any changes made after my dentures are completed will result in an**

**additional fee.**

**\_\_\_\_\_ 6. Endodontic Treatment (Root Canal)**

**I understand that complications can occur from endodontic treatment. I understand**

**that my tooth may be lost in spite of all efforts to save it. I also realize that**

**occasionally the filling used to treat a root canal may extend through the root which**

**can impede the success of the treatment. I understand that additional surgical**

**procedures like apicoectomy, a surgical endodontic procedures, may be necessary**

**following root canal treatment.**

**\_\_\_\_\_7.Prophylaxis**

**I understand that I will be receiving a prophylaxis which is a procedure to remove**

**plaque, calculus and stains from my teeth. I understand this procedure is for patients**

**with healthy mouth condition, not for patients with periodontal disease.**

**\_\_\_\_\_8. Periodontal Therapy (Tissue and Bone)**

**I understand that I have a serious condition of the gum inflammation/infection and/or**

**bone loss that can lead to the loss of my teeth. Alternative treatment plans, including**

**periodontal (gum) surgery, non-surgical periodontal therapy: antibiotic therapy,**

**replacements and/or extractions, have been explained to me. I understand that any**

**dental procedure may have a future adverse effect on my periodontal condition.**

**\_\_\_\_\_9. Fillings/Restorations**

**I understand that I may experience sensitivity after receiving a new amalgam and**

**composite fillings. I understand that I may need more extensive filling that originally**

**diagnosed if additional decay is discovered during the procedure. During the first 24**

**hours after receiving my filling, I should exercise caution and avoid chewing hard and**

**sticky foods to avoid damaging my teeth.**

**\_\_\_\_\_10. Crown/Bridge**

**I understand that my artificial teeth may not match the exact color of my natural**

**teeth. I also understand that I may be wearing temporary crown that I may be**

**permanently cemented into place, until the permanent crown is made. I must be**

**careful to ensure that the temporary crown remains in place until the permanent**

**crown is delivered. I understand that the final opportunity to make changes on my**

**new crown and/or bridge (including shape, fit, size and color) will be prior to final**

**I have read and understand the information above. I have received adequate information about proposed treatment: I understand the treatment, and all my questions have been fully answered. I also understand that it is my responsibility to work with the administrative and clinical staff to establish and keep appointments to allow sufficient time for the recommended procedures.**

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**Signature of Patient or Guardian Date**