**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**

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 **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**