General Dentistry Informed Consent Form

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*******PLEASE INITIAL: EXAM, X-RAY & TREATMENT PLAN AT FIRST VISIT.***

• Examination and X-Rays(initial)____

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

•Treatment Plan (initial) ____

I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative Procedures.

*******INITIAL AS NEEDED:***

•Drugs and Medications (initial) ____

I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching,vomiting and/or anaphylactic shock.

•Fillings (initial) ____

I understand that care must be exercised in chewing on filling teeth, especially during the first 24 hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decays I understand that significant sensitivity is a common after effect of newly placed fillings.

•Crowns, Bridges, Veneers (initial) ____

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 come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation.

•Extractions (initial) ____ Tooth #:_____ Date:_____ / Tooth #:_____ Date:_____

Alternatives to removal of teeth have been explained to me (If applicable: root canal therapy, crown and bridge procedures, periodontal therapy, etc.) I understand removing teeth does not always remove the infection, if present, and 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, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

•Periodontal Disease (initial) ____

I understand that I have been diagnosed with a serious condition, causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. Alternative treatments have been explained to me, including gum surgery, tooth extraction and/or replacement.

•Partials and Dentures (initial) ____

I understand the wearing of partials/dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed at a later date. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of my partial/denture. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, additional charges could be incurred.

I understand that dentistry is not an exact science and 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.

By signing this document, I agree that I have read and understand the consent to the above procedures if needed.

Patient Signature_____ Date_____

Dentist Signature:_____ Date_____