PATIENT NAME_____ CHART #_____

INFORMED CONSENT

1. ANESTHESIA

I realize the risks involved in receiving an anesthetic, some of which are: upset stomach, dizziness, vomiting, sore arm, inflamed vessels of the arm, adverse reactions to drugs causing cardiac arrest, miscarriage, dislodging or chipping teeth and jaw bone.

2. DRUGS AND MEDICATIONS

I understand that anitbiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of the tissues, pain, itching, vomiting, and/or anaphalactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary. I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforseen conditions that may be encountered during the operation.

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 _____. I understand that 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 (parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. (Initials) _____ Date: _____

5. CROWNS , BRIDGES AND CAPS

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 I must be careful to ensure that they are kept on until permanent crowns are delivered. I choose to proceed with the following: _____ (Initials) _____ Date: _____

6. DENTURES - COMPLETE OR PARTIAL

I realize that full or partial dentures are aritificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. I choose to proceed with the following: _____ (Initials) _____ Date: _____

7. ENDODONTIC TRETMENT (ROOT CANAL)

I realize that 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 extend through the root which does not necessarily effect the success of the treatment. I choose to proceed with the following: _____ (Initials) _____ Date: _____

8. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflamation or loss and that it can lead to the loss of my teeth and other complications. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, treated teeth may require extraction. I choose to proceed with the following : _____ (Initials) _____ Date: _____

9. FILLINGS

I have been advised by the Dentist that the silver amalgam restoration is an acceptable procedure according to ADA guidelines and as such is a treatment provided by this office. The advantages and disadvantages of the silver fillings and alternative materials such as composite fillings have been explained to me and I choose the following: _____ (Initials) _____ Date: _____

The effect and nature of the procedures to be performed and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me. Alternative and possible reactions have been explained to me clearly. complications such as infections, hemorrage and/or bleeding, scarring, contractions, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia), fractured jaw, etc., have been clearly explained to me.

I understand that the practice of Dentistry and Surgery is not an exact science and as such, reputable practitioners cannot properly guarantee results. I acknowlege that no gurarantee or assurance has been to me by anyone regarding the treatment which I have requested and authorized. I also understand that it is my responsibility to inform the Dentist if I am having any problems during or following treatement so as to allow him to help minimize any problems. (Initials) _____

I understand that I am fully responsible for the charges incurred as a result of treatment provided to me, regardless of insurance coverage. I hereby authorize any insurance benefits to be made to the Dental Office directly by the Insurance Carrier. (Initials) _____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS REFERRED TO ABOVE WERE MADE TO ME AND MY QUESTIONS ANSWERED. I ALSO UNDERSTAND THAT CUSTOM MADE APPLIANCES ARE NON-REFUNDABLE.

Signature: _____ Relationship: _____ Date: _____

Doctor: _____ Witness: _____