

GENERAL CONSENT AND INFORMATION FORM

It is the belief of this office that you should be informed about the treatment (therapy) we may recommend, and that you should give your consent before starting that treatment. The purpose of this form is to tell of the risks that may occur in dental treatment, and other treatment choices.

RISKS OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

CHANGES IN TREATMENT PLAN: I understand 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. I give my permission to the Dentist to make any/all changes, additions and/or deletions as the Dentist deems necessary.

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, and understand the risks involved, as well as the possible alternative methods of treatment that have been fully explained to me. I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve my condition, or treat unhealthy or unforeseen conditions that may be encountered during treatment.

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 treatment which I am requesting and authorizing. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist, individual, or corporation, other than the treating Dentist, is responsible for my dental treatment. In order to receive treatment I contract that if there is any difference or disagreement between my attending Dentist and myself I will first present such difference or disagreement to my attending Dentist to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the grievance committee of my dental health plan, the Dental Society, or California State Consumer Affairs Board of Dental Examiners, and agree to accept their resolution in lieu of pursuing remedies by way of litigation, in consideration of helping to keep costs of treatment and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members.

Alternatives and possible untoward reactions have been explained to me in detail and clearly, including (but not limited to) bleeding, scarring, numbness, fractured jaw, and allergic reactions which on occasion can be life threatening. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: _____
Patient or Legal Representative

Date: _____

INFORMED CONSENT

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings Bridges Crowns Extractions
Impacted Teeth Removed Root Canals Dentures , Partials , Periodontics , Cleaning Other
(Initials) _____

2. DRUG AND MEDICATIONS

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

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. (Initials) _____

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____
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 (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. (Initials) _____

5. 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. (Initials) _____

6. 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 that I must be careful to ensure that they are kept on until the permanent crowns are delivered. (Initials) _____

7. DENTURES - COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, 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. (Initials) _____

8. ENDODONTIC TREATMENT (ROOT CANAL)

I realize 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. (Initials) _____

9. 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 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. (Initials) _____

10. 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 used by _____ The advantage and disadvantage of alternate materials has been explained to me. (Initials) _____

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

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 unforeseen conditions that may be encountered during the operation. Joint pain (TMJ) may occur due to opening for dental treatments.

I know that the practice of Dentistry and surgery 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 treatment which I have herein requested and authorized.

I also understand that it is my responsibility to inform the Dentist if I am having any problems during or following treatment so as to allow him to help minimize any problem. (Initials) _____

Alternative and possible untoward reactions have been explained to me in detail and clearly. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, 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. (Initials) _____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: _____ Relationship _____ Date _____
Patient or Legal Representative

Doctor: _____ Witness _____