desertpearl DENTISTRY

INFORMATIONAL PURPOSES ONLY

GENERAL DENTISTRY INFORMED CONSENT

Dentist: _____ Patient: _____

1. WORK TO BE DONE: I understand that I am having the following work done: X-rays ( ), Scaling & Root Planing ( ), Fillings ( ), Crowns ( ), Bridges ( ), Root Canals ( ), Dentures ( ), Extractions ( ), Bone Grafting ( ), Other ( ). **(Initials____)**

2. DRUGS AND MEDICATION: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. **(Initials____)**

3. 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. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. **(Initials____)**

4. SCALING AND ROOT PLANING: I understand that I have a serious condition (periodontal disease) causing gum and bone inflammation or loss that can lead to the loss of my teeth. I understand that scaling and root planing is a needed procedure to help reduce the disease symptoms and improve my gum and bone health. Alternative treatments may be needed such as gum surgery, tooth extractions, and replacements. I understand that undertaking any dental procedure may have a future adverse affect on my periodontal health. **(Initials____)**

5. FILLINGS: I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. **(Initials____)**

6. CROWNS, BRIDGES, AND VENEERS: 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. I realize the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or veneer. I understand that there will be additional charges for remakes due to my delaying permanent cementation. **(Initials____)**

7. ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. **(Initials____)**

8. DENTURES / PARTIAL DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. 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 30 days, there will be additional charges. **(Initials____)**

9. TOOTH EXTRACTION: 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:_____and any others necessary for reasons in paragraph #3. 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 (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 for which is my responsibility. **Initials____)**

10. BONE GRAFTING: (A) *Types of graft material.* I understand that some bone graft and membrane material commonly used are derived from human or other mammal sources and are thoroughly purified by different means to be free from contaminants. I give my approval for the doctor to use such materials according to his knowledge and clinical judgment. (B) *Loss of all or part of the graft.* I understand that success with bone and membrane grafting is high. Nevertheless, it is possible that the graft could fail. Despite meticulous surgery, particulate bone graft material can migrate out of the surgery site and be lost and membrane grafts can dislodge. If so, I should notify the doctor. My compliance is essential for success. (C) *Bleeding, bruising, and swelling.* I understand that some moderate bleeding may last several hours and some swelling is normal, but if I have profuse bleeding or severe swelling, I should notify the doctor. I understand that swelling usually starts to subside after about 48 hours and bruises may persist for about a week. (D) *Infection.* I understand that no matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur postoperatively which may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, I should contact the doctor as soon as possible. **(Initials____)**

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.

I hereby authorize Dr. Brian P. Black or his dental associates and auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees. I agree to pay any attorney's fees, or court costs, that may be incurred to satisfy this obligation.

Signature of Patient _____ Date: _____

Signature of Dentist _____ Date: _____