PATIENT CONSENT FORM

1. **DRUGS, MEDICATIONS AND ANESTHESIA**

Initials: _____

BENEFITS: I understand that the administration of anesthetics during and medications following the required dental treatment is to provide therapeutic comfort from undersirable effects that could occur during and following my treatment.

RISKS:

- I understand that upon injection of a local anesthetic, I may sustain a prolonged numbness reaction known as (Parasthesia) which may occur for an indefinite period of time. This condition will be defined by various degrees of numbness, itching or irritation in the area of the injection. I understand that this condition may be unavoidable and it will require proper supportive treatment.
- I understand that antibiotics, analgesics and other medications may cause adverse reactions, some of which are, but not limited to redness, swelling of tissues, pain, itching, vomiting, dizziness, miscarriage and cardiac arrest.
- I understand that during the period of time I will be on any prescribed medications, I have been informed not to consume alcohol beverages or any self prescribed medications. Prescription medications may lead to drowsiness and lack of coordination which can be enhanced by the consumption of alcohol or drugs.
- I understand that if I should select any type of sedation for treatment, possible risks are expected not limited to, loss of consciousness, obstruction of the airway, anaphylactic shock or possible cardiac arrest. Should I be sedated for treatment I will be required to have someone drive me home and monitor me closely for 8 to 10 hours to insure I do not experience any deleterious side effects including an obstruction of the airway.

1. **HYGIENE AND PERIODONTAL CARE** Initials: _____

Hygiene*:* I understand that the long term health of my periodontal tissue is dependent upon my commitment to regular oral hygiene care and consistent recall appointments.

BENEFITS: Healthy oral hygiene condition and the prevention of periodontal disease.

Periodontal Treatment: I understand that I have a serious oral condition causing gum and bone inflammation that left untreated can lead to destruction of supporting bone and eventually cause the premature loss of some or all of my teeth. Untreated periodontal disease may also lead to serious systemic health problems. I understand that there is no cure for perio disease but different modalities of treatment are available for the long term control of the infection.

BENEFITS: I understand that proper and immediate periodontal treatment will help to alleviate gum disease by removing harmful bacteria which will allow the healing of healthy tissue. Various treatments have been explained to me including the benefits of deep scalings gum surgery accompanied by frequent recall visits for maintenance. Should the treatments available to me by the dentist prove to be ineffective I will be offered the opportunity to be referred to a specialist for continued treatment. I also understand that the success of periodontal treatment is dependent upon my commitment to follow oral hygiene instructions and to return for continuous maintenance recalls.

RISKS: I understand that neglecting my periodontal condition could potentially lead to loss of teeth and cause systemic health problems. I also understand that due to the nature of periodontal disease there are no guarantees of success and attempted treatment procedures may be minimally successful requiring specialty referral.

2. **REMOVAL OF TEETH** Initials: _____

I understand that the purpose of surgical procedures is to treat and correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery my present oral condition will worsen in time. It has been explained and I understand the inherent risks involved in undergoing surgical procedures as described under Risks.

BENEFITS: By removing untreatable teeth, pain, swelling and infection will subside, the surgical area will heal enabling the dentist to provide proper dental replacements, and will contribute to my overall physical health.

RISKS:

- Injury to the nerve underlying the teeth resulting in prolonged numbness (parasthesia) that can last for an indefinite period of time. Other symptoms include itching, burning of the lips, cheek or tongue.
- Post-operative discomfort, swelling, delayed healing secondary infection requiring medications or additional treatment.
- Injury to adjacent teeth, caps or fillings (requiring recementation of crowns, replacement of fillings).
- Limitation of opening of the jaw, stiffness of facial or neck muscles, change in the bite or TMJ (temporal mandibular joint) dysfunction.
- Residual root fragments or bone spicules retained following removal.
- Possible bone fractures requiring additional surgery.
- Perforation of the sinus cavity (upper teeth only) requiring additional surgery.

I give my consent for the doctor to perform the treatment/procedure previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation. If any unforeseen situation should arise in the course of the operation calling for the doctor's judgment or additional procedures from those contemplated I

authorize the doctor to do whatever he deems advisable including referral to another dentist or specialist. I also understand that the cost of this referral could be my responsibility.

1. **FILLINGS** Initials: _____

BENEFITS: Amalgam (silver fillings) or composite plastic fillings are a conservative restorative dental treatment which involves the removal of decay with minimum tooth preparation, less treatment time and moderate costs as compared to more extensive crown or cap restorations.

RISKS: Over time fillings will wear, break or redecay requiring additional more extensive treatment.

Even though the silver amalgam restoration is an acceptable safe procedure according to the American Dental Association guidelines, I have been informed of any potential health risks of having amalgam restorations placed as a dental remedy.

2. **ENDODONIC TREATMENT (ROOT CANAL THERAPY)** Initials: _____

The treatment consists of removing the nerve from the tooth and sealing it with a therapeutic filler which allows the tooth to be retained in the mouth and restored.

BENEFITS: Endodonic treatment, when successful, insures that teeth can be retained and restored for an indefinite period of time. Preventing the loss of teeth eliminates more costly procedures such crown and bridge work or implants. Teeth left untreated could lead to serious systemic problems.

RISKS

- Temporary or permanent numbness in the treatment area.
- Post-treatment discomfort lasting for up to several days, treatable by prescription medication.
- Post-treatment swelling adjacent to the treated area which may persist for up to several days or longer.
- Restricted jaw opening.
- Breakage of root canal instruments during procedure which, based upon the judgment of the treating doctor, the fragment may require removal or safely be left in the tooth as part of the root canal sealant.
- Perforation of the tooth by root canal file which may require surgical intervention or premature loss of the tooth.
- If root canal treatment is not finalized but only temporarily medicated the area exposed itself to infection and/or tooth loss.
- Failure of root canal therapy requiring retreatment including apioectomy or in some cases extraction.

1. **CROWN AND BRIDGE** Initials: _____

BENEFITS: Permanent restoration of severely damaged to decayed dentition for functional and cosmetic purposes.

RISKS:

- During the preparation of a tooth pulp exposure may occur necessitating possible root canal therapy.
- Sometimes it is not possible to match the color of natural teeth exactly the artificial teeth.
- If proper oral hygiene is not maintained completed restorative work may fail due to redecay or gum disease.
- Prolonged wearing of temporary crowns or bridges may lead to redecay or breakage of the prepared teeth.
- Failing to have permanent restorations completed in a timely manner may cause the restorations not to fit due to natural movement of teeth.

7. DENTURES – COMPLETE OR PARTIAL Initials: _____

BENEFITS: The removable restoration of missing teeth for functional and cosmetic purposes being more cost effective than either fixed bridge work or implants.

RISKS:

- Improper fitting leading to soreness, looseness, possible breakage.
- Tissue changes leading to the need for frequent relines.
- Stress on supporting teeth leading to potential early tooth loss.
- Complicating factors involving surgical procedures i.e. tori removal, bone recontouring or implants to insure proper denture fit.
- Failure to achieve proper fit of dentures requiring use of adhesives.

8. PEDODONTICS (CHILD DENTISTRY) Initials: _____

BENEFITS: Insure the proper growth and development of the child's dentition by establishing regular recalls, prophys, fluoride treatments, sealants and restorations. During treatment certain supportive treatment techniques may be advised by the doctor including; positive reinforcement, voice control, physical restraint, and possible sedation.

RISKS:

- Child may inadvertently bite their lip or tongue during the period of time when anesthetic has been administered requiring the patient to be returned to the office for evaluation if the injury does not subside after a sufficient period of time.
- Under normal circumstances anesthetics i.e. nitrous oxide or oral sedation may have temporary effects on the child following treatment, such as drowsiness, nausea, delayed post operative discomfort.

- Any unusual post-operation response that is left unobserved could lead to serious consequences, therefore if swelling or pain persists following treatment the patient is to return to the dental facility immediately for evaluation.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS CARE, REALIZING THAT ANY LACK OF COMPLIANCE COULD RESULT IN LESS THAN OPTIMUM RESULTS. I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND UNDERSTAND THE TERMS AND WORDS WITHIN THIS DOCUMENT AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS AND HAVE THEM ANSWERED TO MY SATISFACTION.

Signature of Patient/Legal Representative _____ Relationship _____ Date _____

Doctor: _____ Witness _____ Date _____

NOTICE OF PRIVACY RIGHTS:

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. *You have the right* to express complaints to us if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and dating this form.

I have read and reviewed the **complete** form of *Notice of Privacy Practices*. I have asked all questions regarding this form.

_____
Patient/Guardian Signature

Date_____/_____/_____