LIFETIME dental care

Patient ID:_____

GENERAL DENTISTRY INFORMED CONSENT

Patient:_____

Changes in Treatment Plan

_____ Initials

I understand that due to changing conditions it may be necessary to change or add procedures because of findings not presented during the initial examination. I understand that I will be informed of these changes before clinical treatment.

Anesthetics & Medications

_____ Initials

I understand that Anesthetic and Medications may be used in the course of my treatment. These drugs may cause complications in the form of sensitivity or allergic reactions such as: swelling, muscle soreness, itching, discomfort, intestinal distress or anaphylactic shock. I authorize the Doctor to use whatever drugs or resuscitative procedures he may deem necessary.

Radiographs (X-rays)

_____ Initials

I am herein advised that:

- I am to receive a full mouth series every five years which will provide diagnostic information and documentation for teeth and surrounding hard tissue.
- I will receive periodic examination x-rays for the correct and accurate diagnosis of the teeth.
- I will consent to diagnostic x-rays at a frequency as assessed by the doctor.
- All reasonable precautions will be taken to minimize exposure to radiation.

Fillings

_____ Initials

I am herein advised that:

- Plastic and Amalgam material is not permanent, and is subject to deterioration and fracture.
- I should avoid biting my tongue, cheek or lip while I am affected by local anesthetic.
- I should not chew anything hard for 24 hours.
- Hot or cold sensitivity is a normal reaction to new fillings
- Other complications may occur, such as extractions or root canal therapy.

Veneers (Bonding)

_____ Initials

I am hereby advised that:

- Plastic and Porcelain veneer restorations are subject to failure in the form of discoloration, chipping or breaking.
- I should not chew anything hard against these materials.
- Perfect color match may not be possible.

Crown & Bridge

_____ Initials

I am hereby advised that:

- Perfect match of the color of nature teeth may not be possible.
- Fracture of porcelain material may occur.
- Complications may occur, such as: gum inflammation, gum recession, abscess or broken teeth.
- I will be wearing temporary crown which may come off easily.
- Oral hygiene may affect the longevity of crowns.
- I may undergo a disturbance of my bite, chewing muscles or T.M joint.
- 2 weeks or more normally is required for healing and accommodation for a new crown.

Dentures and Partials

_____
Initials

I am advised that:

- Artificial dentures are constructed of materials which may fail.
- Problems associate with dentures may occur, such as: soreness, looseness, chewing and speech impediment.
- Dentures require periodic relining.
- I will have the opportunity to approve all aspects of my dentures before processing.
- Clasping teeth may cause decay or looseness.

Endodonic Treatment (Root Canal)

_____
Initials

I am advised that:

- Therapy is not always successful, and may lead to loss of tooth. I understand that periodic x-rays are required to ascertain healing.
- Paresthesia or sinus complications may occur, requiring additional treatment.
- Fracture of the tooth or its restoration may occur.
- Surgical procedures may be necessary following root canal therapy.
- Symptoms may occur after therapy, such as sensitivity to percussion, swelling hot or cold.

Oral Surgery

_____
Initials

I am advised that:

- Paresthesia (numbness) may occur.
- Involvement of the sinus may occur.
- Fractures of the jaw, adjacent teeth or restoration may occur, requiring further treatment.
- Symptoms in the form of pain, swelling, bruising, bleeding or nausea may occur.
- Post-operative infections may occur.
- Alternative to extractions have been explained to me, including root canal therapy and periodontal therapy.
- Further treatment by a specialist may be required.

Periodontal Treatment

_____
Initials

I am informed herein that:

- I have Periodontal Disease that could lead to loss of teeth.
- I have been informed that alternative methods of treatment may exist to include maintenance therapy or extraction.
- I understand that if no treatment is rendered the risk may include, but are not limited to the following: loss of teeth, gum recession, halitosis, losing of teeth, abscesses, tooth movement, and further progression of my periodontal disease.
- Risk of therapy include, but are not limited to: pain, swelling, thermal sensitivity, recession infection, tooth mobility, food impaction, and other.
- I agree to follow the home care prevention techniques and the treatment regimen as counseled by the staff.

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. 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.

Signature: _____ Date: _____

Patient, Parent or Legal Guardian