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GENERAL DENTISTRY INFORMED CONSENT

1. TWO PARTS TO AN EXAMINATION (INTRA-ORAL EXAM & RADIOGRAPHIC EXAM): I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan. I understand that by declining x-rays, *half of the examination will be missing* and can lead to serious consequences.

2. 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 teeth (examples-cracks, fractures, or deep decay) that were not discovered during examination, examples include- a larger restoration, a crown, root canal therapy, or an extraction.. I give my permission to the Dentist to make any or all changes and additions to the treatment plan as necessary.

3. DRUGS, MEDICATIONS AND DENTAL ANESTHESIA: I understand that antibiotics, analgesics, and local anesthetics can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Anesthesia may cause temporary or permanent nerve injury. Numbness, altered sensation, tingling sensation to the lip, chin, cheek, gums, teeth and tongue (which may be permanent) may result. Risks of anesthesia for dental treatment include altered sensation, tingling, shooting pain, and numbness of lip, tongue, chin, cheek, bone, and teeth which may be temporary or permanent. Medications may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand this and fully agree not to operate any vehicle after being prescribed narcotic medications. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance that effects treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. I also understand that some medications prescribed by other physicians may effect my oral cavity and/or interact with medications prescribed by the Dentist.

4. FILLINGS: I understand that when the Dentist informs me I have a cavity or fractured tooth or broken filling that it is my responsibility to schedule an appointment. Delaying treatment recommendations can lead to root canal or extraction. I understand that care must be exercised in chewing on a filling during the first 24 hours to avoid breakage. Tooth sensitivity is a common after-effect of a newly placed filling. I understand that if my restoration feels "high" when I bite together after a procedure, that I need to contact the Dental office to schedule an appointment to adjust. Failure to do so can damage the tooth and lead to a root canal or extraction.

5. CROWNS, BRIDGES, VENEERS AND BONDING: 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 realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

6. DENTURES – COMPLETE OR PARTIAL: I realize that full or partial dentures are artificial, constructed of plastic and/or metal. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make change in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement if placed after extractions because bone shrinkage occurs.

7. PERIODONTAL TREATMENT: I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand that treatment plans (non-surgical cleaning, gum surgery and/or extractions) may vary depending on the severity of periodontal conditions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

8. REMOVAL OF TEETH (EXTRACTION): I understand that if a tooth is not savable by e.g. root canal therapy, crowns, periodontal surgery, etc., it may be recommended that the tooth be extracted. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand that the following are some risks involved in having teeth removed: pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

9. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ): I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature but may be permanent.

CONSENT: I have read and understood the above information. Further, I understand that dentistry is not an exact science; therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance as been made by anyone regarding the dental treatment which I have requested and authorize. 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 other than the treating Dentist is responsible for my dental treatment.

SIGNATURE: _____ **DATE:** _____

