GENERAL DENTISTRY INFORMED CONSENT

Chart Number_____

Name_____

1. **Work to be done**

I understand that I am having the following work done: Fillings____, Bridges____, Crowns____, Extractions____ Impacted teeth removed____, General Anesthesia____, Root Canal___, Others X-Rays, (Initials_____)

2. **Drugs and Medications**

I understand that antibiotics and analgesics and the other medicines ca n 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 or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being Root Canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions 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_____and any other necessary for reasons in paragraph #3. I understand removing teeth does not always removed all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in ahving the teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and sorrounding tissue (parasthesia) that can last for an indefinite period of time (days or month) or fractured jaw. I understand I may need further treatment by an specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsability. (Initials_____)

5. **Crowns, Bridges and Caps**

I understand that sometimes is not possible to match the color of antural 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 the final opportunity to make changes in my crown, bridge or cap (including shape, fit, size and color) will be before cementation. (Initials_____)

6. **Dentures-complete or partial**

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problem of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realized the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures relining approximately three to twelve months after initial placement. The cost for this procedures is not included in the initial denture fee. (Initials_____)

7. **Endodontic treatment (Root Canal)**

I realize there is not guarantee that root canal treatment will save my tooth, and that complications can arise from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root which not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

8. **Periondontal loss (Tissue and Bone)**

I understand that i have a serious condition, causing gum and bone inflammation or loss and that ican lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

I understand that dentistry is not an exact science and therefore reputable practitioners can not properly guarantee results. I acknowledge that no gurantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Signature_____ Date_____

Doctor_____ Witness_____