

Patient _____ Date _____

1. GENERAL

I understand that antibiotics, analgesia, local anesthetic and other medications can cause allergic reactions causing redness and swelling of tissues, numbness of indefinite duration, pain, vomiting, and/or anaphylactic shock. I understand that taking antibiotics can interfere with the effectiveness of oral contraceptives. I understand that administration of local anesthetic or exertion of the jaw during the dental procedure can cause pain and/or restrictive movement in the temporomandibular joint and surrounding muscle. Initial/Date _____ / _____

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 the teeth that were not discovered during examination; for example root canal therapy following routine restorative procedures or crowns. Therefore, fees can only be estimated and are subjected and are subject to modification depending on unforeseen or undiagnosable circumstances that may be that may arise during the course of the treatment. I give permission to the Dentist to make any changes necessary. Initial/Date _____ / _____

3. PHOTOS

I authorize the Dentist and his team to take photographs, intra-oral slides, and/or videos of my face, jaws and teeth. I understand that the photographs, intra-oral slides, and/or videos will be used with as a record of my care, and may be used with or without my given name or with a fictitious name for educational purposes in lectures, demonstrations, advertising, professional publications (dental magazines and journals) and any other lawful purpose. I release and forever discharge him from any claim, demands or liability on account of such use or for the quality of the reproduction of the image. Initial/Date _____ / _____

4. RADIOGRAPHS

I understand that the Dentist requires the use of radiographs to properly diagnose my dental treatment. I understand that the radiographs will be used as a record of my care, and may be used with my given name and sent to my insurance carrier, other Dentists, and for educational purposes in lectures, demonstration, and other lawful purposes. Initial/Date _____ / _____

5. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any other necessary for reasons in paragraph #2. I understand that removing the teeth does not always remove all of the infection, if present, and I may be necessary for further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, bone fracture, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissues (paresthesia) that can last for an indefinite period of time. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. Initial/Date _____ / _____

6. CROWNS, BRIDGES AND CAPS

Conditions that require crowns to be made may also require root canal treatment for their resolution, which sometimes becomes apparent after the crown has been placed. I understand that I may be wearing temporary crowns or permanent crowns with temporary cement that may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are permanently cemented. It is also my responsibility to return for permanent cementation within 45 days of the tooth preparation. Excessive delays may allow tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I realize the final opportunity to make changes in my crown, bridge, or cap (shape, size, fit and color) will be before permanent cementation. Initial/Date _____ / _____

7. ENDODONTIC TREATMENT (ROOT CANAL)

Root canal therapy usually takes several appointments for completion. I understand that I must return for all appointments to complete treatment. I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur, and that occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in 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 as a rule a crown will be necessary in order to prevent the tooth from fracturing. I understand that the tooth may be lost in spite of all effort to save it. Initial/Date _____ / _____

8. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition by complicating oral hygiene procedures. Initial/Date _____ / _____

9. FILLINGS

I understand that care must be exercised in chewing on fillings during the first 24 hours, to avoid breakage. I understand that a more serious extensive filling than originally diagnosed may be required due to additional decay. I understand that a significant sensitivity is a common after-affect on a newly places filling. Initial/Date _____ / _____

10. DENTURES

I understand that the wearing of dentures is difficult. Sores spots, altered speech, and difficulty in eating are common problems. Immediate denture placement after extractions may be painful. An immediate denture 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, and that failure to do so may result in poorly fitting dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges. Initial/Date _____ / _____

Signature (patient, parent or legal guardian) _____ Date _____

Print Name _____ Date _____