Dentistry @ Its Finest

INFORMED CONSENT

1. DRUGS AND MEDICATION

I understand that antibiotics and analgesics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

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Initials

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 the 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. No procedure will be performed without informing the patient of the procedure and the cost.

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Initials

3. ANESTHESIA

I realize the risks involved in receiving an anesthetic, some of which are; upset stomach, dizziness, vomiting ,sore arm, inflamed vessels of the arms, adverse reactions to drugs causing cardiac arrest, miscarriage, dislodging or chipping teeth and jaw bone.

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Initials

4. FILLINGS

I have been advised by the dentist that the silver amalgam restorations and composite restorations are acceptable procedures according to ADA guidelines. The advantage and disadvantage of alternate materials has been explained to me.

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Initials

I hereby request and authorize the operating Dentists and their staff to preform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissue as explained above. The effect and nature of the proceeding to be performed and the risks involved as well as the possible alternative methods of treatment have been fully explained to me. I authorize the operating Dentists and assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation. 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 requested and authorized. I understand that it is my responsibility to inform the dentist if I am having any problems during the following treatment so as to allow him to help minimize problems. Alternative and possible reactions have been explained to me clearly and in detail. Complications such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues, fractured jaw, etc. have been clearly explained to me. I certify that I have read and fully understand the above consent to dental treatment and that the explanations therein referred to were made. Anything I did not understand has been explained to me.

Signature: _____ **Date:** _____

Doctor: _____ **Witness:** _____ **Date:** _____