

INFORMED CONSENT GENERAL DENTISTRY

Please read the following information and sign at the bottom of the back page

1. **PHOTOS AND IMAGES:** Unless otherwise indicated, I hereby give my consent to take photographs, slides, videotape and/or computer images of face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry. I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record. I do not expect compensation, financial or otherwise, for the use of these images. I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulation. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. However, the refusal may cause the result of the treatment not to be the best possible. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization.
I DO consent to the use of my photographs, slides, videotape and computer images: X_____initial
I DO NOT consent to the use of my photographs, slides, videotape and computer images: X_____initial
2. **X-RAYS:** Unless otherwise indicated, I hereby give my consent to take x-rays. I understand the benefits and advantages for the x-rays as an additional diagnostic tool for treatment planning. X-rays reveal undersurface details that are not visible to the naked eyes. Even though x-rays may not reveal all vital information. I understand that, without an x-ray, there are details and pathology may be missed to aid in making an accurate diagnosis. In refusing the recommended x-rays, I take full responsibility of any undiagnosed interproximal cavities (cavities in between the teeth), any undiagnosed tumors, cysts, or abscessed teeth found in the oral cavity, and bone loss which may be noted on the dental x-rays. Bone loss is monitored on x-rays because it occurs with Periodontitis (Gum Disease), which can result in loss of teeth if not diagnosed and treated. The standard regimen for taking dental x-rays is once every three to five years for a Full Mouth Series, and every one to two years for the bitewing x-rays which are taken in between the dates of the Full Mouth Series. I DO consent to take x-ray of teeth, tissue and bone: X_____initial
I DO NOT consent to take x-ray of teeth, tissue and bone: X_____initial
3. **DRUGS, MEDICATIONS:** I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
4. **CHANGE 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.
5. **REMOVAL OF TEETH:** Risks, benefits and alternatives to tooth removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth and any other necessary procedures. Side effects to medications as described in section 3 under drugs may occur. I understand removing teeth does not always remove all of the tooth or infection, if present. And it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time, fractured jaw, sinus complications involving openings and or infections requiring other surgeries, bleeding, chronic pain and dysfunction of the jaw joint (TMJ), vision or hearing loss, referred neck pain, and damage to the surrounding teeth. I understand I may need further treatment by a specialist or even hospitalization if complications arise or following treatment, the cost of which is my responsibility
6. **FILLINGS:** I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling and this could lead to more work such as a root canal, crown, etc.

CONTINUE ON THE BACK PAGE

7. **PERIODONTAL LOSS (TISSUE & BONE):** I understand that periodontal disease is 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, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. I understand failure to do advised treatment will cause progression of the disease and loss of my teeth.

8. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment even including tooth loss. I understand that I may need further treatment, by a specialist, if complications arise during or following treatments such as; twisted curved or blocked canals, preventing removal of all infected pulp form roots, broken instruments, filling past the end of the tooth, not completely filling the canal, all which may require more treatment and even possible surgery, the cost of which is my responsibility. Complications can occur such as; pain, swelling, bleeding, infections, numbness of the teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time, muscle cramps and spasms, referred neck pain, chronic pain and dysfunction of the jaw joint (TMJ), reactions to medications as listed above in section 1, bruises, sinus complications, sight and hearing impairment, all possible requiring further treatment by a specialist, the cost of which is my responsibility. I understand the need to place a permanent restoration to the tooth; failure to do so may cause failure to the root canal and even tooth loss.

9. **CROWNS, BRIDGES AND CAPS AND VENEERS:** 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 realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit size, and color) will be my responsibility before cementation. It is also my responsibility to return for permanent cementation with in 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of a crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that due to the delay further treatment such as root canals, perio defects, gum problems, and even loss of the tooth can result. I understand that due to the very nature of a crown that tissue cannot attach like a natural tooth surface and subsequent periodontal defects and problems can occur.

10. **DENTURES-COMplete OR PARTIAL:** I understand that wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extraction) may be painful. Immediate dentures 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 of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is due to my delays of more than 30 days there will be additional charges.

I understand that dentistry 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 dental treatment, which I have requested and authorized. 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 or the professional corporation is responsible for my dental treatment. I hereby authorize any of the doctors, hygienist, or dental auxiliaries of Spectrum Dental Group to proceed with and perform the dental restoration and treatments for the patient named below. I understood that this is only an estimate and subject to modification depending on unforeseen or previously undiagnosed circumstances that may arise during the course of treatment. I have read, understood, and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this assignment.

Patient Name (Print)

Birth Date

Signature of Patient, Parent, or Guardian

Parent, or Guardian Print name

Date

Doctor