General Dentistry Informed Consent

Patient Name_____

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. Treatment to be Provided: I understand that during my course of treatment that the following care may be provided:

I understand that I am having the following done: (Initials: _____)

Filling Bridges Crowns Extractions Impacted Teeth Removed
Root Canals Dentures Periodontal Treatment Other X-Ray Exam

2. Drugs and Medications: (Initials: _____)

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.

3. Changes in Treatment Plan: (Initials: _____)

I understand that during treatment it may be necessary to change or add procedures cause of conditions found while working on the teeth that were not discovered during examination, for example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

4. Removal of Teeth: (Initials: _____)

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 others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks 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 (Parathesia) that can last for an indefinite period of time or fractured jaw. 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.

5. Crowns, Bridges, and Caps: (Initials: _____)

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 before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for 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 cementation.

6. Endodontic Treatment (Root Canal): (Initials: _____)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the root, which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost, despite all efforts to save it.

7. Periodontal Loss (Tissue & Bone): (Initials: _____)

I understand that I have 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.

8. Fillings: (Initials: _____)

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is common after effect of a newly placed filling. I understand that my insurance company may pay benefits on these fillings based on the fee for amalgam (mercury) fillings.

9. Dentures: (Initials: _____)

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) 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 required due to my delay of more than 30 days, there will be an additional charge.

10. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **(Initials_____)**

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 nor Norfolk Family & Pediatric Dentistry is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries of the Norfolk Family & Pediatric Dentistry to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Should any dispute arise over dental services provided to me, that is whether any dental service rendered as allegedly unnecessary, unauthorized, or was improperly, negligently, or incompetently performed, said dispute will be submitted by Peer Review by the local component of The American Dental Association. The decision of Peer Review shall be binding on both parties. 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_____ Signature_____ Date: _____

Doctor:_____ Date: _____