



General Dentistry Informed Consent Form

Treatment Plan... I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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. For example, root canal therapy following routine restorative procedures.

Drug and Medications... I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.

Extractions... Alternatives to removal of teeth have been explained to me (root canal therapy, crown and bridge procedure, periodontal therapy, etc.) and I understand removing teeth does not always remove the infection, if present, and 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 (parasthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Crowns, Bridges, 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 come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Endodontic Therapy... I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand the endodontic files and reamers are very fine instruments and stresses and defects in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following the root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to restore it.

Periodontal Disease... I understand that I have been diagnosed with a serious condition, causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. Alternative treatments have been explained to me, including gum surgery, tooth extraction and/or replacement.

Fillings... I understand that care must be exercised in chewing on filling teeth, especially during the first 24 hours to avoid breakage. I understand that significant sensitivity is a common after effect of newly placed fillings.

Partials and Dentures... I understand the wearing of partials/dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline due will be needed at a later date. This IS NOT included in the denture fee. I understand that it is my responsibility to return for delivery of my partial/denture. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, additional charges could be incurred.

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.

Patient Signature, Parent/Guardian

Date



Information Regarding Bisphosphonates

Bisphosphonate are a class of drugs that are used to treat osteoporosis in women. Stronger forms of bisphosphonates are sometimes used in the treatment of certain cancers, as well as for a disorder called Paget’s disease.

A connection has been made between bisphosphonate type drugs and a serious bone disease called Osteonecrosis of the Jaw. The United States Food and Drug Association, along with the manufacturer of one of these drugs (Fosamax) issued a warning to health care professionals on this issue on September 24th, 2004.

It is very important for you to let us know if you are now, or have ever in the past, taken ANY type of bisphosphonate class drug. If we treat you without knowing if you are now, or have ever taken in the past, any of these drugs, your health could be seriously affected. These drugs continue to affect the body for years after they are no longer being taken, so we must know if you have ever taken any of them. Brand names of these drugs include (but are not limited to) the following:

- Fosamax
- Zometa
- Aredia
- Actonel
- Boniva
- Bonefos
- Skelid
- Didronel

Are you now, or have you in the past, taken a bisphosphonate drug, including any of the brands listed above?

YES _____ NO _____ DATE _____

Patient Signature **Date**

Information on the Election of Treatment

Your dentist will design a treatment plan in which he/she will recommend that you undergo specific dental procedures. You will be presented with the optimum treatment for your particular dental needs. If, in the dentist’s judgment, other acceptable treatment options exist, these will be discussed with you as well. There are likely to be increased risks and potential complications should you elect to have an alternative form of treatment that differs from the optimum treatment plan presented to you. Please discuss these issues in more detail with your dentist. Be sure to understand the potential risks and complications before consenting to treatment.

Witness

Patients Signature Date

Witness

Signature of Parent/Guardian Date