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Patient Name _____

Informed Consent Form for General Dental Procedures

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.

Please 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 treatment, you acknowledge 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.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

1. EXAMINATION AND X-RAYS

I understand that examinations may require radiographs in order to complete the examination, diagnosis, and treatment planning.

2. DRUGS, MEDICATION, AND SEDATION

I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. 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 teeth that were not discovered during initial examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually temporary in nature and well tolerated by most patients. I understand that should the need for treatment arise, I will be referred to a specialist for treatment, the cost of which is my responsibility.

5. FILLINGS AND RESTORATIONS

I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

6. REMOVAL OF TEETH (EXTRACTION)

If applicable or when needed, alternatives if available to removal of teeth will be explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and 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 I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: I understand that dentistry is not an exact science, therefore: reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance as been made by anyone regarding the dental treatment which I have requested and authorize. 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 other than the treating Dentist is responsible for my dental treatment.

Patient/Legal Guardian Signature _____ Date _____

Printed Name _____

Witness Signature _____ Date _____