INFORMED CONSENT

Please fill out this form, print it and bring it with you to your appointment.

Patient Name: _____

Chart #: _____ *(for office use only)*

1. WORK TO BE DONE
    a. I understand that I am having the following work done:
    b. Fillings ☐ Bridges ☐ Crowns ☐ Dentures ☐ Partials ☐ Periodontics ☐ Cleaning ☐ Other ☐ _____ *(patient Initials)* _____

2. DRUG AND MEDICATIONS
    a. 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 reactions). *(patient Initials)* _____

3. CHANGES IN TREATMENT PLAN
    a. I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during initial examination. I give my permission to the Dentist to make those changes as necessary. *(patient Initials)* _____

4. REMOVAL OF TEETH
    a. 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 _____.

    b. I understand removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment. *(patient Initials)* _____

    c. 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 (days or months) or fractured jaw. *(patient Initials)* _____

d. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. *(patient Initials)* _____

5. ANESTHESIA
   a. I realize the risks involved in receiving anethesia, some of which are: upset stomach, dizziness, vomiting, sore arm, inflamed vessels of arms, adverse reactions to drugs causing cardiac arrest, miscarriage, dislodging or chipping teeth and jaw bone. *(patient Initials)* _____

6. CROWNS, BRIDGES AND CAPS
   a. 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 a temporary crown, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. *(patient Initials)* _____

7. DENTURES - COMPLETE OR PARTIAL
   a. I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. *(patient Initials)* _____

8. ENDODONTIC TREATMENT (ROOT CANAL)
   a. 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, metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of treatment. *(patient Initials)* _____

9. PERIODONTAL LOSS (TISSUE AND BONE)
   a. I understand that I have a serious condition, causing gum and bone inflammation or loss that can lead to the loss of my teeth and other complications. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, treated teeth may require extraction. *(patient Initials)* _____

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10. I have been advised by the Dentist that the silver amalgam restoration is an acceptable procedure according to the ADA guidelines, and, as such, is a treatment used by Advanta Dental Group. The advantage and disadvantage of alternate materials has been explained to me. *(patient Initials)* _____
    a. I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and health of my mouth, teeth, bone, and tissues, as explained above. *(patient Initials)* _____
    b. 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. *(patient Initials)* _____
    c. I also authorize the operating Dentist 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. *(patient Initials)* _____
    d. 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 herein requested and authorized. *(patient Initials)* _____
    e. I also understand that it is my responsibility to inform the Dentist if I am having any problems during or following treatment so as to allow him to help minimize any problem. *(patient Initials)* _____
    f. Alternative and possible untoward reactions have been explained to me in detail and clearly. Complications such as, infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parathesia), fractured jaw, etc., have been clearly explained to me. *(patient Initials)* _____

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.

Patient Signature: _____ Relationship: _____ Date: _____

Doctor Signature: _____ Witness: _____