Claremont Design Denstry

GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME: _____

1. **WORK TO BE DONE-** I understand that having the following work done: Fillings ____, Bridges ____, Crowns ____, Extractions ____, Impacted teeth removed ____, Root Canal ____, Dentures ____, Floride_____, Other (Exam & X-rays) Prophy_____, Full Mouth Debridement_____.

(Initials_____)

2. **DRUGS AND 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.

(Initials_____)

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 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 as necessary.

(Initials_____)

4. **REMOVAL OF TEETH-** Alternative to removal has been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any other necessary for reasons in paragraph # 3. I understand removing teeth does not always remove all the infection, if present, and it may 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 n my teeth, lips, tongue and surrounding tissue

(Parasthesya) 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.

(Initials_____)

5. **CROWNS, BRIDGES, AND CAPS-** I understand that sometimes it is not easy 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 permanent cementation.**

(initial_____)

6. **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, and that occasionally root canal fillings material may extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root treatment (apioectomy). I understand that the tooth may be lost despite all effort to save it.

(Initials_____)

7. **PERIODONTAL LOSS (TISSUE & BONE)** – I understand that I have 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, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials_____)

8. **DENTURES-** I understand the 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. Permanent reline will be needed later. This is not included in the fees. I understand that it is my responsibility to return for delivery of the dentures. **I understand that failure to keep my delivery may result in poorly fitted dentures. If remake is required due to my delays for more than 30 days there will be additional charges.**

(Initials_____)

9. **FILLINGS:** I understand that care must be exercised in chewing on fillings especially during the first 24 hrs to avoid breakage. I understand that a more extensive filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

(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 neither Dentist nor Dental Group is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries of Claremont Design 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 necessary treatment 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 fees that may be incurred to satisfy this obligation.**

Should any dispute arise over dental services provided to me, that are whether any dental services rendered allegedly unnecessary, unauthorized or were improperly, negligently or incompetently performed, said dispute submitted to Peer Review by the local component of The American Dental Association. The decision of Peer photocopy of this authorized shall be as valid and effective as the original forever I am of legal age and legally competent to make this assignment.

Signature: _____ Date:_____

Doctor: _____ Date: _____