Saxon Dental General Dentistry Informed Consent

Patient:_____ Dentist:_____

1) **WORK TO BE DONE**

I understand that I am having the following work done: Exam (XX), X-rays (XX), Fillings ( ), Extractions ( ), Crown and Bridge ( ), Root Canal ( ), Dentures ( ), Partial ( ) (Initials_____)

2) **DRUGS AND MEDICATION**

I understand that antibiotics (interferes with effectiveness of contraceptives), analgesics, and other medication 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 the routing restorative procedures. (Initials_____)

4) **REMOVAL OF TEETH**

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 reason 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, MPS, tongue and surrounding tissue (paresthesia) 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.

- ❑ Tooth # (s)_____ Date:_____ (Initials_____)
- ❑ Tooth # (s)_____ Date:_____ (Initials_____)

5) **FILLINGS**

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 a common after effect of a newly planted filling.

- ❑ Tooth # (s)_____ Date:_____ (Initials_____)
- ❑ Tooth # (s)_____ Date:_____ (Initials_____)
- ❑ Tooth # (s)_____ Date:_____ (Initials_____)

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 the canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally (Apicoectomy). I understand that the tooth may be lost in spite of efforts to save it.

- ❑ Tooth #(s)_____ Date:_____ (Initials_____)

7) **DENTURES**

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be necessary later. This is not included in the denture fee. I understand that it is my responsibility to return for deliver of dentures. I understand that failure to keep delivery appointment may result poorly fitting dentures. If a remake is required due to my delays of more that 30 days, there will be additional charges.

The denture try-in appointment is designed to allow the patient to approve the cosmetic aspects of the denture. Please look closely at the size, shape, color, fullness, and arrangement of the teeth.

I understand that any changes after the denture is completed will result in the charge of the lab fees.
(Initials_____) (Date:_____)

8) **CROWNS, BRIDGES AND CAPS**

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 changed 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 20 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 remake due to my delaying permanent cementation.

- ❑ Tooth # (s)_____ (Date:_____) (Initials_____)
- ❑ Tooth # (s)_____ (Date:_____) (Initials_____)

9) **PERIDONTAL LOSS (TISSUE AND BONE**)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to 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 affect on my periodontal condition. (Initials_____) (Date_____)

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 no other dentist is responsible for my dental treatment.

I hereby authorize any of the doctors of dental auxiliaries 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 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 attorney's fees, collections fees, or any costs that may be incurred to satisfy this obligation.

_____ _____

Signature of Patient OR Parent if under 18 Date

_____ _____

Signature of Dentist Date