PLAZA FAMILY DENTAL

General Dentistry Informed Consent

1. WORK TO BE DONE

I understand that I am having the following work done by initiating one or more of the following procedures:

Fillings__________Bridge__________Crown__________Extractions__________Root Canals__________ Full Dentures__________
Partial Dentures__________ Other___________________ Exam and or X-rays__________

2. Drugs and Medication

I understand that antibiotics and other medications can cause allergic reactions. This can result in redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. For Women I understand that taking antibiotics may cause any birth control medications I am taking to become ineffective.

Date: __________ Initials: __________ Date: __________ Initials: __________ Date: __________ Initials: __________

3. Changes in Treatment Plan

I understand that during the 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 may be necessary following routine restorative procedures. I give my permission to the dentist to make any changes and additions as deemed necessary.

Date: __________ Initials: __________ Date: __________ Initials: __________ Date: __________ Initials: __________

4. Removal of Teeth

Alternatives to removal of tooth/teeth have been explained to me (root canal therapy, crowns, periodontal surgery. Ect.) and I authorize the Dentist to remove the following tooth/teeth ____________________ and any others necessary for reasons in paragraph #3. I understand that the extraction of teeth does not always completely remove the infection that is 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, lips and surrounding tissues (Parasthesia) that can last for an indefinite period of time. I understand I may need further treatment by a specialist if complications arise during the following treatment and the cost of which is my responsibility.

Date: __________ Initials: __________ Date: __________ Initials: __________ Date: __________ Initials: __________

5. Fillings

I understand that care must be exercised in chewing on fillings especially the first 24 hours to avoid breakage or fractures. I understand that more extensive filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of newly placed filling/fillings.

Date: __________ Initials: __________ Date: __________ Initials: __________ Date: __________ Initials: __________

6. Endodontic Treatment (Root Canals)

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 a root canal filling may be slightly short of the root tip or It may Extend beyond the root tip, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost despite all efforts to save it.

Date: __________ Initials: __________ Date: __________ Initials: __________ Date: __________ Initials: __________

7. Periodontal Disease (Loss of Bone/Tissue)

(Healthy gums do not bleed)

I understand that I have a Serious/Moderate condition involving both my gums, bone and supporting structures of the mouth and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including the possible need for gum/bone surgery replacements and/or extractions:

Date: __________ Initials: __________ Date: __________ Initials: __________ Date: __________ Initials: __________

8. Crowns, Bridges, veneers and Inlay/Onlay

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 restoration which may come off easily and that I must be careful to ensure that they are kept on until the permanent restoration can be cemented in place. I realize the final opportunity to make changes in my new restoration including shape, size, fit and color will be before the final cementation. It will be my responsibility to return for permanent cementation within 30 days from the tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a new impression/remake or the restoration. I understand the there will be additional charges for remakes due to my delaying permanent cementation.

Date: __________ Initials: __________ Date: __________ Initials: __________ Date: __________ Initials: __________

9. Dentures, Partials and Stayplate

I understand that the wearing of dentures is a difficult skill. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures will require considerable adjustments and several temporary relines. A permanent reline or even a new permanent set of custom dentures may be required at a later time determined by the dentist. The reline and/or new dentures process is not included in the original estimate. I understand it is my responsibility to return for insertion of dentures. If a remake is required due to my delay of more than 30 days there will be additional charges.

Date: __________ Initials: __________ Date: __________ Initials: __________ Date: __________ Initials: __________

I understand dentistry is not an exact science and 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 no other Dentist is responsible for my treatment, I hereby authorize any of the doctors and/or dental auxiliaries to proceed with and perform the dental restorations and treatment as explained to me.

I understand the 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 costs that may be incurred to satisfy this obligation. I have read, understood, and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this agreement.

Every responsible effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

Any unresolved dispute between Plaza Family Dental Group and the patient related to their dental treatment will be settled by mediation. If mediation is unsuccessful this dispute will be settled by binding arbitration using an arbitrator of the American Arbitrator Association. The patient agrees the mediation and arbitration will be the only remedy. Both parties to this agreement consent to allow the arbitrator to conduct discovery related to the dispute. The arbitration process shall provide remedies to the parties in the dispute including a written opinion.

Patient/Guardian______________________________________ Doctor______________________________ Date__________________

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Patient/Guardian______________________________________ Doctor______________________________ Date__________________