INFORMED CONSENT FOR TREATMENT

Please read and initial. If you have any questions, please ask your dentist.

1. DRUGS, MEDICATION AND SEDATION

- I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
- I have informed the Dentist of any known allergies.
- I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or exasperated infection, increased pain, and potential resistance to effective treatment of my condition.
- I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills), if applicable.
- I understand that local anesthesia is utilized to numb tissue for certain dental procedures.
- I understand that some patients may experience temporary increased heart rate, allergy, soreness, nerve, or blood vessel bruising, tingling. persistent numbness or trauma after a dental procedure.
- Itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Initials _____

2. CHANGES IN TREATMENT PLAN

- I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed.
- 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, the most common being root canal therapy following routine restorative procedures.
- I give my permission to the Dentist to make any and all changes in treatment plan as necessary.
- I understand that any associated laboratory fees are my financial responsibility.

Initials _____

3. DENTAL BENEFITS

- I understand that my insurance may only provide coverage for the minimum standard of care.
- I understand that submitting insurance and receiving a benefit is my responsibility and that any assistance from Mid-City Smiles Family Dentistry is completely voluntary.
- Regardless of the response from my insurance carrier, I elect to follow the Dentist's recommendation for optimal dental treatment.

Initials _____

4. EXAMINATIONS AND X-RAYS

I understand that my initial visit may require radiographs to complete the examination diagnosis and treatment plan. I understand that **Mid-City Smiles Family Dentistry** has set standard intervals for radiographs to aid in the diagnosis of oral lesions, decay between the teeth, bone loss, gum disease, cysts, tumors, infections, and impacted teeth.

Initials _____

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. I understand bleeding could last several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted.

Initials _____

6. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling. I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation which may lead to other measures necessary to restore the tooth to normal function.

Initials _____

7. REMOVAL OF TEETH

- I understand that there are alternatives to removal (root canal therapy crown, periodontal surgery, etc.,).
- I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Other risks, some of which are: pain, swelling, dry sockets, spread of infection, bleeding, exposed sinuses, fracture of jawbone, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period.
- I understand that 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.

Initials _____

8. CROWNS, BRIDGES, VENEERS AND BONDING

- 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 that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation.
- I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.
- I understand that there will be additional charges for remakes or other treatment due to my delaying permanent cementation and/or any complications that may arise during treatment. I understand that any additional costs incurred are my responsibility.

Initials _____

9. DENTURES • COMPLETE OR PARTIAL

- I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit.
- Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later.
- I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
- I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges which are my responsibility.

Initials _____

10. ENDODONTIC TREATMENT (ROOT CANAL)

- I realize there is no guarantee that root canal treatment will save my tooth, 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 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.

Initials _____

11. PERIODONTAL TREATMENT (TISSUE AND BONE)

- I understand gum inflammation and/or bone loss can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre- term labor, etc.).
- I understand that there are alternative treatment plans, including non- surgical therapy, antibiotic/antimicrobial treatment, gum surgery and/or extractions.
- I understand bleeding could last for several hours. Should bleeding persists particularly if it is severe in nature, it should receive attention and this office must be contacted.

Initials _____

12. BLEACHING TEETH

- I understand that the degree of whitening varies with the individual. The average patient achieves considerable change.
- I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity.
- Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics with unknown risks. Acceptance of treatment means acceptance of risk.
- Pregnant women are advised to consult with their physician before starting treatment.

Initials _____

13. TMJ/TEMPOROMANDIBULAR JOINT DYSFUNCTION

- I understand that TMJ may need treatment over several years which might include orthodontic treatment, tooth restoration with crowns and bridges or even surgery.
- I understand that complications might include, but are not limited to: pain, bruising and swelling; potential damage to teeth, fillings or bridges; nerve damage causing temporary or permanent numbness of the chin, tongue, lips or face; pain and spasms in the neck, ear, face, head and back.

Initials _____

14. BONE GRAFT

- I understand that a bone graft is derived from human bone that has been collected, stored, and processed according to the standards for Tissue Banking of the American Association of Tissue Banks and Food and Drug Administration Regulations.
- There have been no reports of disease transmission during the thirty plus year history of using freeze-dried bone for socket preservation.

Initials _____

15. ORTHODONTICS

- Successful outcome is dependent on patient compliance, consistent wearing of the aligners, individual patient physiology, and tooth form.
- It is important to wear the aligners for at least 22 hours a day and remove the aligners for eating and drinking followed by immediate oral hygiene.
- Throughout the course of treatment, changes in your bite may occur, and it may take an adjustment phase for you to get used to these changes in your bite, muscles, and joints. You may experience some slight soreness and speech changes which are usually quickly self-limiting.
- Your impressions, x-rays and photographs are sent to an outside vendor for the treatment planning phase and manufacturing of the aligners.
- During or after the course of treatment, certain tooth restorations may need to be replaced based on functional or esthetic needs in the newer, more ideal position.

Initials _____

16. REQUIRED DEPOSIT ON TREATMENT

- I understand that a deposit will be required on all dental treatment prior to scheduling the appointment.

Initials _____

17. NITROUS OXIDE

- If I elect to have Nitrous Oxide, I understand possible side effects may occur. These include, but are not limited to, nausea, vomiting, dizziness, and headache.

Initials _____

I have had the opportunity to read this form and understand that I can direct all my questions to my dentist.

My signature below signifies that I understand and consent to treatment that may be proposed for me, together with any known risks and/or complications associated with the treatment.

_____ _____

Patient Signature (or Legal Representative) Date