INFORMED CONSENT

PATIENT NAME: _____ CHART NO.: _____
(Please print Name)

1. WORK TO BE DONE

I understand that I am having the following work done: Filling ☐, Bridge ☐, Crown ☐, Extractions ☐, Impacted Teeth Removal ☐, Root Canals ☐, Dentures ☐, Partials ☐, Periodontics ☐, Other ☐

2. DRUG AND MEDICATONS

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and /or anaphylactic shock (severe allergic reaction).

3. CHANGE IN TREATMENT PLAN

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 examination. I give my permission to Dentist to make those changes as necessary.

(Initial _____)

4. REMOVAL OF TEETH

Alternative to removal have been explained t me (root canal therapy, crown and periodontal surgery, etc) and I authorize the Dentist to remove the following teeth _____ and any other necessary under paragraph #3. I understand that removing teeth does not always remove all the infection, and if present, it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry pocket, loss of feeling in my teeth, lips, tongue and surrounding tissues (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further by a specialist or even hospitalization if complication arise during or following treatment.

5. ANASTHESIA

I realize the risk involve in receiving a local anesthetic , some of which are : partial facial paralysis, inflamed tissue, adverse reactions to drug causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness.

6. CROWN, BRIDGE 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 kept on until the permanent crowns are delivered, and that if I don't have permanent crown(s) placed, permanent serious damage or loss of the tooth/teeth involved may ensue, and that if I delay placement , I ma cause teeth involved to move so that the permanent crown no longer will fit properly.

7. DENTURES-COMPLETE OR PARTIAL

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 and bone change.

8. ENDODONTIST TREATMENT (ROOT CANAL)

I realize there no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally metal object are cemented in the teeth or extended through the root which does not necessarily effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if not complete the prescribed treatment.

9. PERIODONTAL 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 the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacement and/or extraction.

(Initial _____)

I hereby request and authorize the Dentist, and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of proceeding to be performed, and the risk involve, as well as possible alternative method of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure that they may deem necessary or desirable in attempt to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen condition that may be encountered during the operation.

I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable parishioners 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 authorize.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and /or bleeding, scarring, contraction, possible deformities, prolong healing time over the estimate, reaction to any drug before, during and after surgery, numbness or itching of the tongue, lips, teeth, tissue(Parasthesia), fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TRREATMENT AND THAT THE EXPLANATIONS THEREIN REFERED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: _____ Date: _____
Patient or Legal Representative

Witness: _____ Date: _____