

# PATIENT CONSENT TO TREATMENT

In reading and signing this form it is understood that **ENGLISH** is the language that I understand and use to communicate.

(Initials)\_\_\_\_\_

**[ ] DRUGS, MEDICATIONS, AND ANESTHESIA:**

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medication and/or drugs, until fully recovered from their effects.

I understand that upon injection of a local anesthetic, I must be careful biting, chewing or eating until I regain normal feeling. Occasionally, I may experience prolonged, persistent anesthesia, numbness, bruising and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloryl hydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest.. I understand that someone needs to drive me home from the dental office after I have received sedation except for Nitrous Oxide, in which case I may be able to drive.

(Initials)\_\_\_\_\_

**[ ] HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):**

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and by maintaining regularly scheduled hygiene visits.

PERIODONTICS- I understand that if I have Periodontal Disease, I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to the loss of my teeth as well as certain medical conditions. The various treatment options have been explained to me, including non-surgical scaling and root planing, periodontal surgery, extractions and the need for tooth replacement. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

(Initials)\_\_\_\_\_

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of the referral would be my responsibility.

(Initials)\_\_\_\_\_

**[ ] FILLINGS:**

I have been advised of the need for fillings, usually Resin Bonded Composite (tooth colored), to replace tooth structure lost to decay. I understand that with time the fillings will need to be replaced due to wearing material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

I understand that following the placement of fillings, it is normal to experience tooth sensitivity that may include cold or hot, biting pressure, sensitivity to flossing or brushing and/or sensitivity when eating certain foods. This subsides with time in most cases, however in some cases additional treatment, including root canal therapy may be necessary.

(Initials)\_\_\_\_\_

**[ ] ENDODONTICS TREATMENT (ROOT CANAL THERAPY):**

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

I understand the treatment risks can include, but are not limited to the following:

- A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
- B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
- C. Infection.
- D. Restricted jaw opening.
- E. Breakage of root canal instruments during treatment, which may in the judgment of a doctor be left in the treated root canal or bone as a part of the filling material, or it may require surgery for removal.
- F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
- G. Risk of temporary or permanent numbness in treatment area.

( ) PULPOTOMY:

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

(Initials) \_\_\_\_\_

[ ] CROWN AND BRIDGE (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times following the preparation of a tooth for a crown, it is normal to experience tooth and or gum tissue sensitivity for a period of time following the procedure. If a pulp exposure occurs during the procedure or sensitivity does not subside, root canal therapy may be needed.

I understand that like with natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(Initials) \_\_\_\_\_

[ ] DENTURES- COMPLETE OR PARTIAL:

The problems of wearing removable partial dentures or full dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori[bone]removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

(Initials) \_\_\_\_\_

[ ] PEDODONTICS (CHILD DENTISTRY):

I understand that the following procedures are routinely used as well as being accepted procedures in the dental profession.

- A. POSITIVE REINFORCEMENT - Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
- B. VOICE CONTROL - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctors voice.
- C. NITROUS OXIDE AND/OR ORAL SEDATION - Nitrous oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent/or guardian must be understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

(Initials) \_\_\_\_\_

**I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.**

(Initials) \_\_\_\_\_

**I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSITE SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.**

(Initials) \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_