PATIENT CONSENT TO TREATMENT

Patient's Name / Guardian (Print): _____ Date: _____

1. **DRUGS, MEDICATIONS AND ANESTHESIA** Initials: _____

BENEFITS: I understand that the administration of anesthetics during and medications following the required dental treatment is to provide therapeutic comfort from undersirable effects that could occur during and following my treatment.

RISKS:

- I understand that antibiotics, analgesics and other medications may cause adverse reactions, some of which are, but not limited to redness, swelling of tissues, pain, itching, vomiting, dizziness, miscarriage and cardiac arrest and/or anaphylactic shock (severe allergic reaction).
- I understand 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 to operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of a least twenty-four (24) hours after release from surgery.
- I understand occasionally, upon injection of a local anesthetic, I may have or sustain a prolonged persistent anesthesia, numbness reaction known as (Parasthesia) which may occur for an indefinite period of time. This condition will be defined by various degrees of numbness, itching or irritation in the area of the injection. I understand that this condition may be unavoidable and it will require proper supportive treatment.
- I understand with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the patient may inadvertently bite their lip causing injury to occur.
- I understand that if I should select any type of sedation (Nitrous Oxide,Zanax, Valium, Chloral Hydrate, etc) for treatment, possible risks are expected not limited to, loss of consciousness, obstruction of the airway, anaphylactic shock or possible cardiac arrest. Should I be sedated for treatment I will be required to have someone drive me home and monitor me closely for 8 to 10 hours to insure I do not experience any deleterious side effects including an obstruction of the airway. Oral sedative medications, such as Valium, require I have driving arrangements to and from the dental office.

2. **HYGIENE AND PERIODONTAL CARE** Initials: _____

Hygiene*:* I understand that the long term health of my periodontal tissue is dependent upon my commitment to proper and regular oral hygiene care (i.e. brushing and flossing) and consistent recall appointments.

BENEFITS: Healthy oral hygiene condition and the prevention of periodontal disease.

Periodontal Treatment: I understand that I have a serious oral condition causing gum and bone inflammation that left untreated can lead to destruction of supporting bone and eventually cause the premature loss of some or all of my teeth. Untreated periodontal disease may also lead to serious systemic health problems. I understand that there is no cure for perio disease but different modalities of treatment are available for the long term control of the infection.

BENEFITS: I understand that proper and immediate periodontal treatment will help to alleviate gum disease by removing harmful bacteria which will allow the healing of healthy tissue. Various treatments have been explained to me including the benefits of deep scalings gum surgery accompanied by frequent recall visits for maintenance. Should the treatments available to me by the dentist prove to be ineffective I will be offered the opportunity to be referred to a specialist for continued treatment. I also understand that the success of periodontal treatment is dependent upon my commitment to follow oral hygiene instructions and to return for continuous maintenance recalls.

RISKS: I understand that neglecting my periodontal condition could potentially lead to loss of teeth and cause systemic health problems. I also understand that due to the nature of periodontal disease there are no guarantees of success and attempted treatment procedures may be minimally successful requiring specialty referral.

3. **REMOVAL OF TEETH** Initials: _____

I understand that the purpose of surgical procedures is to treat and correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery my present oral condition will worsen in time. It has been explained and I understand the inherent risks involved in undergoing surgical procedures as described under Risks.

BENEFITS: By removing untreatable teeth, pain, swelling and infection will subside, the surgical area will heal enabling the dentist to provide proper dental replacements, and will contribute to my overall physical health.

RISKS:

- Injury to the nerve underlying the teeth resulting in prolonged numbness (parasthesia) that can last for an indefinite period of time. Other symptoms include itching, burning of the lips, cheek or tongue.
- Post-operative discomfort, swelling, delayed healing (dry socket) and/or infection (requiring medications, prescriptions or additional treatment or surgery).
- Injury to adjacent teeth, caps or fillings (requiring recementation of crowns, replacement of fillings, fabrication of crowns or extraction), or injury to other tissues not within surgical area.
- Complications of Oral Surgery are the following: Limitation of opening of the jaw, stiffness of facial and/or neck muscles, change in the bite or TMJ (temporal mandibular joint) dysfunction (possibly requiring physical therapy or surgery).
- Residual root fragments or bone specula's left when complete removal would require extensive surgery or needless complications.
- Possible bone fracture, which may require wiring or surgical treatment.
- Opening of a sinus (abnormal cavity situated above the upper teeth) requiring additional surgery.
- Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, guns, cheek, teeth, an/or tongue on the operated side; this may persist for several weeks, months, or, in remote instances, permanently.

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 situation or condition should arise in the course of the operation calling for the doctor's judgment or for the procedures in addition to or different from those not contemplated, I request and authorize the doctor to do whatever they deem advisable including referral to another dentist or specialist. I also understand that the cost of this referral could be my responsibility.

4. FILLINGS Initials: _____

BENEFITS: Amalgam (silver fillings) or composite plastic fillings are a conservative restorative dental treatment which involves the removal of decay with minimum tooth preparation, less treatment time and moderate costs as compared to more extensive crown or cap restorations.

RISKS: Over time fillings will wear, break or redecay requiring additional more extensive treatment.

- I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand with time, fillings will need to be replaced due to wearing of the material. In cases were very little tooth structure remain, or existing tooth fractures off, I may need to receive more extensive treatment (such as a root canal therapy, post, and buildup, and crowns) which would necessitate a separate charge.
- I understand silver amalgam restoration is an acceptable safe procedure according to the American Dental Association (ADA) guidelines and as such, is a treatment used by Del Dental Group. The advantages and disadvantage have been explained to me.

5. ENDODONIC TREATMENT (ROOT CANAL THERAPY) Initials: _____

The treatment consists of removing the nerve from the tooth and sealing it with therapeutic filler which allows the tooth to be retained in the mouth and restored.

BENEFITS: Endodonic treatment, when successful, insures that teeth can be retained and restored for an indefinite period of time. Preventing the loss of teeth eliminates more costly procedures such crown and bridge work or implants. Teeth left untreated could lead to serious systemic problems. I UNDERSTAND THAT TREATMENT RISK CAN INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING:

RISKS

- Temporary or permanent numbness in the treatment area.
- Post-treatment discomfort lasting for up to several days, treatable by prescription medication.
- Post-treatment swelling adjacent to the treated area which may persist for up to several days or longer.
- Restricted jaw opening.
- Breakage of root canal instruments during procedure which, based upon the judgment of the treating doctor, the fragment may require removal or safely be left in the tooth as part of the root canal sealant.
- Perforations of the tooth by root canal file which may require surgical intervention or premature loss of the tooth.
- If root canal treatment is not finalized but only temporarily medicated the area exposed itself to infection and/or tooth loss.
- Failure of root canal therapy requiring retreatment including apioectomy or in some cases extraction.
- If an"open and medicate" or pulpotomy procedure is performed, I understand this is not permanent treatment, and I will need to pay the services, and finish the final root canal therapy. If the root canal therapy is not finalized I may expose myself to infection and/or tooth loss. If failure of root canal occurs, the treatment might have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

6. CROWN AND BRIDGE Initials: _____

BENEFITS: Permanent restoration of severely damaged to decayed dentition for functional and cosmetic purposes.

RISKS:

- I understand sometime it is not possible to match the color of natural teeth exactly with artificial teeth.
- I understand at times during the preparation of a toot for a crown, pulp exposure may occur, necessitating for possible root canal therapy.
- I further understand I may be wearing crowns, which may come off easily and I must be careful to ensure that they be kept on until the permanent crowns are delivered.
- I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit size, and color) will be before cementation.
- If proper oral hygiene is not maintained completed restorative work may fail due to redecay or gum disease.
- Prolonged wearing of temporary crowns or bridges may lead to redecay or breakage of the prepared teeth.
- Failing to have permanent restorations completed in a timely manner may cause the restorations not to fit due to natural movement of teeth and will be the responsibility of the patient and may incur extra charges.

7. DENTURES – COMPLETE OR PARTIAL Initials: _____

BENEFITS: The removable restoration of missing teeth for functional and cosmetic purposes being more cost effective than either fixed bridge work or implants.

RISKS:

- I understand the problems of dentures have been explained to me including improper fitting leading to soreness, looseness, 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 understand surgical intervention (i.e. tori removal, bone recontouring, or implants) may be needed for dentures to be property fitted. I also understand due to bone loss or other complicating factors; I may never be able to wear dentures to my satisfaction.
- Stress on supporting teeth leading to potential early tooth loss.

8. PEDODONTICS (CHILD DENTISTRY) Initials: _____

BENEFITS: Insure the proper growth and development of the child's dentition by establishing regular recalls, prophys, fluoride treatments, sealants and restorations. During treatment certain supportive treatment techniques may be advised by the doctor including; positive reinforcement, voice control, physical restraint, and possible sedation.

RISKS:

- I understand the following procedures are routinely used at Del Dental Group as well as being accepted procedures in the dental profession.
- POSITIVE REINFORCEMENT – Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/ or token objects or toys.
- VOICE CONTROL – Changing the tone or increasing the volume of the doctor's voice gains the attention of a disruptive child.
- PHYSICAL RESTRAINT - Restraining the child's disruptive movements by holding down their hands, upper body, head and/ or legs by use of the dentist's or assistant's hand or arm.
- NITROUS OXIDE ANS/OR ORAL SEDATION – Nitrous oxide is mild gas that is mixed with oxygen, and is used to dedate 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 and/or guardian must understand 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 sedation procedure, and observe their behavior throughout the day.
- Child may inadvertently bite their lip or tongue during the period of time when anesthetic has been administered requiring the patient to be returned to the office for evaluation if the injury does not subside after a sufficient period of time.
- Under normal circumstances anesthetics i.e. nitrous oxide or oral sedation may have temporary effects on the child following treatment, such as drowsiness, nausea, and delayed post operative discomfort.
- Any unusual post-operation response that is left unobserved could lead to serious consequences, therefore if swelling or pain persists following treatment the patient is to return to the dental facility immediately for evaluation.

9. CHANGES IN TREATMENT PLAN Initials: _____

- I understand during treatment it may be necessary to change or add procedures because of conditions found wil working on the teeth were not discovered during the examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
- I understand the need to return to the dental office, for evaluation, if swelling and/or pain in my mouth do not go away after a sufficient period of time.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN AND 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 THEIR CARE, REALIZING THAT ANY LACK OF COMPLIANCE COULD RESULT IN LESS THAN OPTIMUM RESULTS. I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND UNDERSTAND THE TERMS AND WORDS WITHIN THIS DOCUMENT AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS AND HAVE THEM ANSWERED TO MY SATISFACTION.

Print Name of Patient/Legal Representative _____ Relationship _____ Date _____

Signature of Patient/Legal Representative _____ Date _____

Doctor: _____ Witness _____ Date _____