Camino Dental Group

1328 W. El Camino Real, Mountain View CA 94040. Tel. (650) 962-8773 Fax. (650) 962-8464

Patient Name _____

☐ **1. WORK TO BE DONE**

I understand that the dentist recommended the following treatment. I understand that there are risks for having dental treatment. Some of the common risks are bleeding, post-op sensitivity, nerve infection, swelling, pain, or infection after surgery. It is my responsibility to notify the dentist if problems arise after receiving treatment and schedule a follow-up visit. Some dental treatment requires multiple visits. Failure to return for continuing care might result in unfavorable consequences leading to more dental problems and/or tooth loss. I understand that it is important to have good oral hygiene to prevent decay or gum disease, which could lead to failure of the restoration. Any restoration in the mouth does not last forever and therefore need to be replaced when needed.

_____ Initials _____

☐ **2. DRUGS AND MEDICATIONS**

I understand that local anesthetics, 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). Local anesthetics will cause temporary loss of feeling for 2 to 4 hrs.

Initials _____

☐ **3. CHANGES IN TREATMENT PLAN**

I understand that it may be necessary to change or add procedures because of conditions found during treatment that were not discovered during examination. The most common changes are extension of decay to other tooth surface, decay on other teeth adjacent to working area, extension of decay to the nerve which requires root canal therapy, or severely compromised tooth structure after decay removal resulting in non-restorable condition. The dentist will inform patient if such conditions arise and will recommend additional treatment such as additional fillings, root canal therapy for nerve problem, buildup and crown for compromised tooth, or possible extraction if non-restorable. I give my permission to the dentist to make any/all changes and additions as necessary with my consent.

Initials _____

☐ **4. COMPOSITE RESTORATION**

I understand that the dentist recommended composite restoration(s) or filling(s) due to decay, tooth defect, breakdown of existing restorations, or as a preventive treatment to avoid future problems. I might experience temporary post-operative sensitivity to cold, hot or biting after tooth preparation. If the sensitivity does not resolve, I might have irreversible nerve damage or injury requiring additional treatment such as root canal therapy. Additional treatment such as crown may become necessary when the dentist has determined that the tooth structure is insufficient to place a restoration alone. The warranty for composite is 2 years after initial placement.

Initials _____

☐ **5. PERIODONTAL DISEASE**

I understand that gum disease is a serious condition, causing irreversible gum and bone damage and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including scaling and root planning, gum surgery, and/or extractions. I understand that maintenance therapy after gum treatment is important and that I am responsible for keeping my gums and teeth healthy on daily basis to prevent gum disease from recurring.

Initials _____

☐ **6. CROWNS, BRIDGES, VENEERS, INLAYS, ONLAYS**

I understand that sometimes it is not possible to match the color/shade of my natural teeth exactly with artificial teeth. I 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. It is my responsibility to return for permanent cementation within 20 days from tooth preparation, as time delays may allow for tooth movement, which may necessitate a remake of the crown, bridge or cap. I also understand that during the course of restorative procedures such as crowns or bridges, additional treatment such as crown build-up may become necessary when the dentist has determined that the tooth structure is insufficient to support a crown. I might experience temporary post-operative sensitivity to cold, hot or biting after tooth preparation. If the sensitivity does not resolve, I might have irreversible nerve damage or injury requiring additional treatment such as root canal therapy. I have the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) before cementation. Porcelain crowns are tooth colored esthetic crowns, but they may fracture to excess biting force. The warranty for crown replacement is 3 years after initial cementation. Initials _____

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL THERAPY)**

The purpose of root canal therapy is to remove infected nerve tissue, which has been injured or damaged by decay or trauma. I realize there is no guarantee that root canal therapy will save my tooth, and complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the success of the treatment. I understand that endodontic files and drills are very fine instruments and curvature or calcification present in teeth can cause them to break during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment if healing is not complete (re-treatment, apicoectomy). After root canal therapy, it may be necessary to restore the tooth with a crown or cap to protect the tooth from fracture. Root canal therapy might need to be repeated after several years if tooth show signs of re-infection.

Initials _____

☐ **8. EXTRACTION (REMOVAL OF TEETH)**

Alternatives to extraction have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorized the dentist to remove the following tooth # _____ and any others necessary. I understand that removing teeth does not always remove all the infection, if 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, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months), or fractured jaw or adjacent tooth or restorations. I understand 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. After extraction, it may be necessary to replace missing tooth/teeth to prevent drifting or shifting of other teeth resulting in biting problems. Initials _____

☐ **9. DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial denture(s) are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including bulk of the appliance, food trap, looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture(s) (including shape, fit, size, placement, and color) will be during the "teeth in wax'" try-in visit. I understand that I need to wear my denture(s) daily to prevent shifting of existing teeth that will prevent seating of my dentures correctly. Most dentures require relining approximately 2 years after initial placement as bone and gum tissue shrink over time. The cost for this procedure is not included in the initial denture fee. Restorations such as fillings or crowns placed after the denture(s) are made may cause changes in the fit of the denture resulting in denture replacement. The warranty for denture is 3 years after initial delivery.

Initials _____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully 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 have had the opportunity to read this form and ask questions. I acknowledged that I have been fully informed of the risks and benefits of the proposed treatments, and my questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient/Guardian if patient is a minor _____ Date _____