

Consent For Dental Treatment

Ala Moana Dentistry
Dr. Keiko Watanabe

_____ DRUGS AND MEDICATIONS:

I understand that antibiotics, analgesics, anesthetics and other medications may cause allergic reactions, resulting in redness and swelling of tissues, itching, pain or more severe allergic reactions. I have informed the doctor of any known allergies.

_____ RISKS OF DENTAL ANESTHESIA:

I understand that pain, bruising, and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue or associated facial structure can occur with injections. About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possible treatment may be needed if the symptoms do not resolve.

_____ FILLINGS:

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

_____ PERIODONTAL DISEASE:

Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. I understand that much of the success of periodontal treatment depends of my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

_____ CHANGES IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Patient's or Guardian's Signature _____

Date _____

Witness' Signature _____

Date _____