Family and Cosmetic Dentistry

Dr. Glenn Raj Stanislaus

Dr. Pamela A. Micheloti

4249 Route 9 North, Bldg. 2 - Suite A
Freehold, NJ 07728

732-409-0330

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date:

Name:

LAST FIRST MI MR MRS MS DR

I prefer to be called: ☐ Male ☐ Female

Birthdate: Age: SS#:

Home Address:

APT - CONDO #

CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: Pager/Other#:

WK#: Ext DL#:

Employer:

Employer's Address:

How long there?: Occupation:

Where & when are best times to reach you?

Who may we THANK for referring you?

Other family members seen by us:

Previous/Present Dentist:

(Please Circle)

Last Visit Date:

CELL# E-MAIL ADDRESS-

2 SPOUSE INFORMATION

Their Name:

Employer

WK#: Ext SS#:

Birthdate: DL#:

Person Responsible for Account:

WK#: Ext HM#:

Billing Address:

Zip

Relationship: SS#:

Employer: DL#:

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone#:

Group# (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthday: Insured's SS#.

Insured's Employer:

Secondary Dental Insurance

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone#:

Group# (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthday: Insured's SS#:

Insured's Employer:

In the event of an emergency, is ther someone who lives near you that we should contact?

Their Name: Relation:

WK#: HM#:

4 MEDICAL HISTORY

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name:

Phone#: Date of last visit:

CONTINUED ON BACK OF FORM

4 MEDICAL HISTORY

Your current physical health is ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ No ☐ Yes
Please explain _____

Are you taking any prescription/over the counter drugs? ☐ No ☐ Yes
Please list each one

For Women Are you taking birth control pills? ☐ No ☐ Yes
Are you pregnant? ☐ No ☐ Yes Week# _____
Are you nursing? ☐ No ☐ Yes

Have you ever had any of the following

diseases or medical problems?

Y N Heart Attack/Stroke	Y N Psychiatric Problems
Y N Cancer/Chemotherapy	Y N Epilepsy/Seizures/Fainting Spells
Y N Heart Murmur	Y N Diabetes/Tuberculosis(TB)
Y N Rheumatic Fever	Y N Drug/Alcohol Abuse
Y N HIV+/AIDS	Y N Venereal Disease
Y N Heart Surgery/Pacemaker	Y N Hemophilia/Abnormal Bleeding
Y N Shingles	Y N Ulcers/Colitis
Y N Mitral Valve Prolapse	Y N Congential Heart Defect
Y N Kidney Problems	Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints	Y N Asthma/Arthritis
Y N Artificial Valves	Y N Difficulty Breathing
Y N Sinus Problems	Y N Hospitalized for Any Reason
Y N High/Low Blood Pressure	Y N Hepatitis
Y N Fever Blisters	Y N Blood Transfusion
Y N Severe/Frequent Headaches	Y N Emphysema/Glaucoma

Please list any serious medical condition(s) that you have ever had:
_____
_____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Other
Y N Erythromycin	Y N Codeine	Y N

Please list any other drugs that you are allergic to: _____
_____

5 DENTAL HISTORY

Why have you come to the dentist today?
_____
_____

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ?TMD) ☐ No ☐ Yes

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes

Do your gums ever bleed? ☐ No ☐ Yes

How many times a week do you floss?_____ a day do you brush _____

Type of bristle? ☐ Hard ☐ Medium ☐ Soft

I

understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been made.

!

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herin. Initials _____ Date _____

Doctors Comments: _____

Medical History Update

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____

DR, GLENN R. STANISLAUS
DR. PAMELA A. MICHELOTTI

Name (Last) First Middle INSURANCE CARRIER

Address Zip Phone Parent or Guardian

Date of Birth Sex Marital Status Doctor

Date I hereby give consent for operations, procedures, medications and/or anesthetics as are deemed necessary.

Parent (if minor)

Relationship

Witness

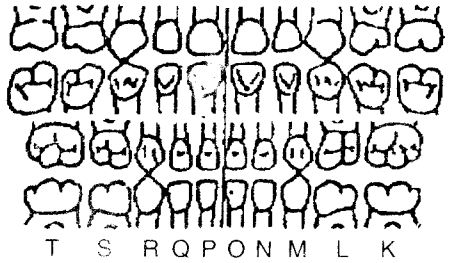
Date of Medical Summary

HISTORY

Sensitivity & Allergies ____ Hepatitis ____
Bleeding ____ Yellow Jaundice ____
Cardiac ____ Tuberculosis ____
Blood Pressure ____ Venereal Disease ____
Diabetes ____ Pregnancy ____
Medications ____
Surgery ____
Past Illnesses ____
Rheumatic Fever ____
Asthma ____
Kidney Disease ____
Liver Disease ____

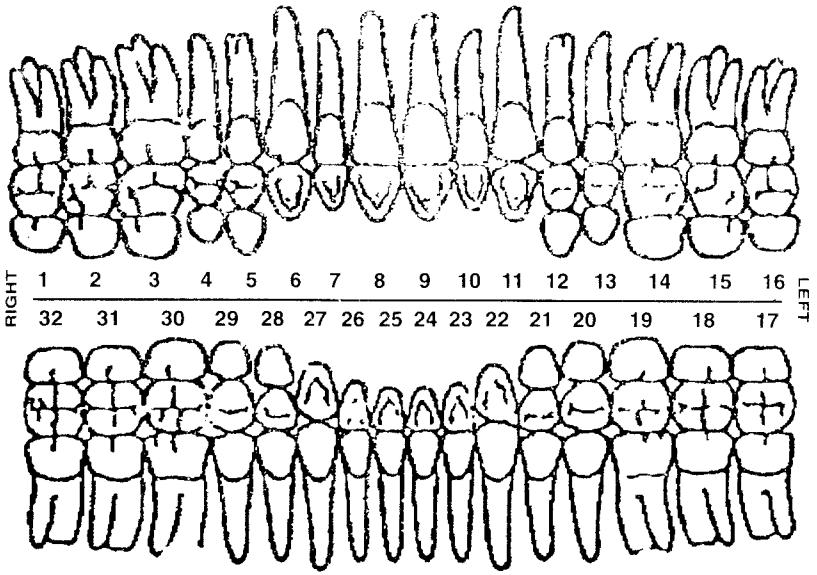
Conditions of Initial Examination

Head and Neck ____ Floor of Mouth ____
Lips ____ Nodes ____
Oral Hygiene ____ Occlusion ____
Gingiva ____ TMJ ____
Tongue ____



Examiner Dr. ____ Date ____

Caries, Dental Disease, Missing Teeth, Abnormalities



CONSULTATIONS

TREATMENT PLAN

Date	Procedure	Doctor's Signature

FAMILY & COSMETIC DENTISTRY

4249 ROUTE 9 NORTH, BLDG. 2 SUITE A
FREEHOLD, NJ 07728
732-409-0330

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003 , and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, letters or postcards).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a flat rate of $25.00 to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Person: ROSANNA CARBONE Phone #: 732-409-0330 Fax #: 732-409-0353

Address: 4249 ROUTE 9N, BLDG 2 SUITE A City: FREEHOLD, NJ 07728

FAMILY & COSMETIC DENTISTRY

4249 ROUTE 9 NORTH, BLDG. 2 SUITE A
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____ Phone #: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health operations, of the uses and disclosures we may make of your protected health information and of other important materials about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: ROSANNA CARBONE Phone #: 732-409-0330

Address: 4249 ROUTE 9N, BLDG. 2 SUITE A City: FREEHOLD, NJ 07728 Fax #: 732-409-0353

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

TFD 4070C

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

FAMILY & COSMETIC DENTISTRY

4249 ROUTE 9 NORTH, BLDG. 2 SUITE A
FREEHOLD, NJ 07728
732-409-0330

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT ***

Name: _____ Date: _____

Address: _____ Phone #: _____

I, _____ *have received a copy of this office's Notice* of Privacy Practices.

Signature: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

FAMILY AND COSMETIC DENTISTRY
4249 ROUTE 9 NORTH, BLDG 2- SUITE A
FREEHOLD, NJ 07728

Informed Consent Document and Agreement

Patient: _____ Date: _____

Patient/Guardian Signature: _____

CLEANING OF THE TEETH - a procedure by which the plaque, superficial stain and tartar are removed from the tooth's surface. This is accomplished by the use of hand, and rotary and/or ultrasonic instruments. The benefit of cleaning the teeth is to help prevent disease to the tooth and supporting tissues of the teeth. Without professional cleaning, there is very likely to be tooth decay, gum disease with the eventual loss of teeth, pain and infection. TOPICAL FLUORIDE is often used to increase the resistance of the enamel against tooth decay. THERAPEUTIC CLEANINGS are recommended when acute or chronic gum inflammation or infection is present which causes bleeding and pain which interfere with the cleaning process. THERAPEUTIC CLEANING usually require a follow up cleaning(s) to complete the tooth cleaning process.

LOCAL ANESTHESIA - Is a state of numbness created by drugs that are injected in the area of nerves to block or reduce pain sensations associated with treatment. RISKS of local anesthesia include prolonged numbness (parasthesia), lip, cheek and/or tongue biting, bruising, swelling and pain in the area of injection. Drugs that you may be taking (prescription and/or no-prescription) can greatly affect the benefits and risk of local anesthesia. IT IS MOST IMPORTANT THAT WE KNOW ABOUT YOUR HEALTH STATUS PROBLEMS AT ALL TIMES.

RESTORATIVE DENTISTRY

ALLOYS - Silver amalgam produces a restoration that will provide many years of service. More posterior teeth are restored with amalgam than any other material. These restorations restore form and function to posterior teeth which are carious (decayed, rotten, etc...); posterior teeth which have old, defective, or fractured amalgams; posterior teeth with recurrent decay; teeth following root canal therapy which require buildups, and sometimes as a core material for teeth with posts.

COMPOSITES - Bonded tooth- colored restoration which is the material of choice to restore carious lesions and other defects in teeth where esthetics is a factor. Also, composites TODAY are excellent as posterior restorations and function as well, or better than conventional amalgam. Composite restorations will discolor and stain over time (after debridement of caries and preparation of teeth, possible pulp exposure can occur, requiring root canal therapy and or possible extraction)

IMPLANTOLOGY - restoration of edentulous areas. Implants are placed into the Jawbone surgically, after osseointegration (body's ability to have bone grow around the Implant) the tooth is restored to assimilate normal function and esthetics as close as possible. Total time period to complete and Implants is approximately 1 year. Possible complications include rejection to implant, infections, periodontal problems, all can cause failure of implants.

LAMINATES - Porcelain veneers may be considered the "state of the art" in cosmetic dentistry because they offer innumerable advantages over any previous form of veneering systems. Laminates are bonded restorations which require minimal tooth preparation and are indicated for teeth which are discolored (tetracycline stain, fluorosis, or devitalized or dead teeth; teeth with enamel defects; teeth with multiple unsightly spaces; slightly rotated teeth; small teeth ; or teeth with numerous shallow unesthetic restorations on the labial surface (front surface) As with all restoration being placed, there is the possibility for increased sensitivity, pain or need of Root canal therapy. Exact color and shape cannot be guaranteed.

TOOTH EXTRACTIONS - With tooth removal (EXTRACTIONS), any of the following may occur: pain, swelling, bleeding, and infection. With any extraction there can be fracture of the tooth resulting in more involved surgery to remove any root or tooth fragments . Should this occur there may be an additional fee for the surgical treatment required. Other possible consequences AFTER tooth removal include "DRY SOCKET" or blood clot degeneration in the extracted tooth socket resulting in pain and a need to return for additional treatment. It is most important that all instructions on post operative care of your mouth and extraction sites be followed.

ORAL SURGERY and SURGICAL TOOTH REMOVAL - It is to be understood that ORAL SURGERY has as a possible consequence of the surgery, anesthesia and/or parathesia. Following this treatment, there may be complications which include the following: infection; bleeding and discoloration (bruises); numbness; stiffness of the neck and facial muscles; change in the bite; jaw joint pain (from keeping the mouth open); injury to adjacent teeth and restorations (fillings); injuries to other tissues; referred pain to ear, head, and neck; nausea and vomiting; allergic reactions to medications; bone fractures; delayed healing; sinus complications from oral openings into the sinus cavities. Anesthetic agents and prescription drugs may cause drowsiness, lack of awareness, and incoordination which may be amplified by the use of alcohol or other drugs. Care should be used in not operating a vehicle or machinery for at least 24 hours or until you have fully recovered. There is no warranty or guaranty as to the result and/or cure. Your full cooperation is required in order to expect reasonable and satisfactory results.

TREATMENT OF INJURED TISSUES (Dentoalveolar)
Dentoalveolar injuries may be caused by force directly on a tooth or an indirect force, most commonly transmitted through overlying soft tissues, such as the lip. Injuries of the soft tissues almost always accompany injuries to the dentoalveolus. Gingival tissues may be torn; the lower lip may have been caught between the teeth during the injury, creating a full- thickness laceration ; the floor of the mouth may be lacerated.

The goal in the treatment of dentoalveolar injuries is reestablishing normal form and function of the chewing apparatus. When the pulp is directly involved, treatment differs from that of tooth injuries in which the pulp is not involved.
Lip lacerations are commonly seen in dentoalveolar trauma, but in many instances of trauma, the teeth are uninjured, the force of the blow having been absorbed by the soft tissues. There are four major steps in the surgical management of lacerations: cleansing, debridement (removing necrotic tissue), hemostasis, and closure. These steps apply to lacerations anywhere in the body, including the oral cavity and perioral areas.

Sealants: A sealant is a clear or shaded plastic material that is applied to the chewing surfaces of the back teeth (premolars and molars), where decay occurs most often. This sealant acts as a barrier, protecting the decay- prone areas of the back teeth from plaque and acid. Each tooth takes only a few minutes to seal. First, the teeth that will be sealed are cleaned. The chewing surfaces are then etched (roughened) with a weak acidic solution to help the sealant adhere to the teeth. Finally, the sealant is brushed on the tooth enamel and allowed to harden. Some sealants need a special curing light to help them harden; others do not.

Habit Control: The purpose of the appliance that your child recieved today is to remind or prevent a thumb or finger habit and to prevent the tongue from pushing against the upper teeth during swallowing. Your child should not be led to think that this appliance is a form of punishment. Rather it is in the mouth as a a reminder. Please note the following:

(1)The appliance should fit in the roof of the mouth without causing the gum tissue to turn white or cause pain (2) Your child should not play with or try to remove the appliance (3)Avoid sticky and hard candies (4) You may expect a slight change in speech and possible drooling for a very short period of time (5)Teeth should be brushed in the usual manner to keep them completely clean (6)It is most important that the six month preventive follow- up appointment be kept to avoid damage or pain to gums and attached teeth

Do not hesitate to call us should there be any unusual discomfort or any concerns about the appliance or the treatment...

FIXED REPLACEMENTS (Crown and Bridge) FOR MISSING TEETH - involves the fabrication of a crown or crowns to restore a tooth (teeth) as closely as possible to its original form and function. This treatment becomes necessary when it is not possible to restore a tooth through the use of a filling. Treatment usually involves the reduction of the natural tooth structure or the use of the root of the tooth to support a post upon which a crown may be constructed. In any case, there is never guaranty of success. Complications arising from Crown and Bridge treatment may include, but not be limited to the following:

1. Exposure of the pulp canal of the tooth requiring an endodontic (root canal) procedure to be performed. If this is necessary, the patient will be responsible for all fees associated with the root canal treatment. It may be necessary to refer the patient for treatment to an endodontist (root canal specialist).
2. The tooth may require root canal treatment without an exposure occurring. Some teeth are unable to withstand reduction procedure. In this case, the patient will be responsible for ensuring that root canal treatment is performed and will be responsible for any fees associated with the root canal treatment.
3. It may not be possible to achieve a level of anesthesia that meets the patient's expectations. In some cases, final tooth form is limited by the existing condition of the patient's mouth.
4. Postoperative discomfort or swelling may occur and last a few hours to several days depending upon the complexity of the case. It is not unusual for this to occur, especially following impression procedures.
5. The patient's bite may feel uncomfortable.
6. The crown may feel fuller than the natural teeth. If a procedure cannot be completed due to a complication, there will be a charge for all procedures performed up to that point. The amount of the charge will be commensurate with the portion of the case that has been finished. There will be a full charge for all completed services. No warranty or guaranty of success can be given in crown and bridge treatment.

PARTIAL and COMPLETE DENTURES Dentures are removable and do not function as well as your natural teeth or a fixed bridge. They can offer you many years of reasonable service and function. Due to the situation created by the loss of teeth, dentures involve some problems which cannot be avoided.

You may experience some soreness under the base where the denture rests on the gum tissue. This may be alleviated by adjustments to the denture and tissue treatment. If this is your first denture it may take you some time to become accustomed to its feel. Even experienced denture wearers need some time to adjust to a new denture. However, any continuing pain or discomfort should be brought to our attention.

COMPLETE DENTURE - The bottom or base of your denture will rest on top of your gum tissue. You should expect that the longer you are without teeth, the less gum and bone support you will have to support your denture.

PARTIAL DENTURE - will be held in place by one or more devices (clasps, rests, keyways, lingual bars) while the complete denture depends on a close fit with the gum tissues within your mouth. Your partial denture may, for purposes of stability, rely in part upon a connection or attachment to your remaining teeth and over time these teeth may be weakened or compromised sooner than if they hadn't been used to help support your denture. Even though your partial denture cannot itself decay, it will trap food particles. Without thorough and regular brushing and cleansing of the denture you may encourage decay to adjacent natural teeth, create or worsen periodontal disease in those adjacent teeth, and promote bad breath.

ROOT CANAL PROCEDURES - are required when due to trauma or infection the nerve tissue (pulp) in your tooth has been compromised and is no longer healthy. The unhealthy nerve tissue is removed from the tooth through an opening into the nerve chamber. This is done as an attempt to save the tooth and to avoid the need to extract your tooth. The results from root canal treatment cannot be guaranteed. The failure rate for root canal treatment is approximately 10 to 15 percent. Following treatment, the tooth will be brittle and subject to fracture. A restoration (filling, crown and/or post and core) will be necessary to restore the tooth to function. The fee for this procedure will be additional. Failure to follow through with the restoration may result in fracture, infection, and/or possible loss of the tooth. Complications arising from the root canal treatment may include, but not be limited to the following:

1. Discomfort afterwards, lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
2. Postoperative 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.
3. Infection
4. Failure rate of 10-15%. (If failure occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted. An additional fee will be charged for each of these procedures).
5. Breakage of root canal instruments during treatment, which may in the judgment of the doctor be left in the treated root canal or require surgery for removal.
6. Perforation of the root canal with instruments, which may require additional surgical corrective treatment or result in premature tooth loss or extraction.
7. Premature tooth loss due to progressive periodontal (gum) disease in the surrounding area. If a root canal treatment cannot be completed due to a complication, there will be a charge for all procedures performed up to that point. There will be a full charge for all completed cases regardless of success or failure. No warranty or guaranty of success can be given in root canal treatment.

TREATMENT OF GUM DISEASE (NON- SURGICAL)

Gum disease is a condition in which loss of supporting tissue (gum and bone) occurs as a result of long- term inadequate removal of plaque by the patient. Treatment consists of debridement or removal of infected gum tissue with the use of specialized instruments. Treatment is usually performed with the use of local anesthesia to provide a higher level of comfort. Plaque, tartar, and stain present on the tooth and roots are removed using hand, rotary, and/ or ultra sonic instruments. Possible complications following non-surgical treatment of gum disease may include, but not be limited to, pain, swelling, bleeding, tooth sensitivity, loosening of the treated teeth, and infection. There is no guarantee as to the result of treatment. Your full cooperation is required following treatment in order to expect reasonable results.