Submit by Email Print Form

INFORMED CONSENT

Name_____ Date _____

1. Work to be Done:
I understand that I am having the following done: Fillings _____ Bridge _____ Crown _____ Extraction _____
Impacted teeth removed _____ IV Sedation _____ Root Canals _____ Other_____ Initial ____

2. Drugs and Medications:
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction) initial ____

3. Change in Treatment Plan:
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during 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, after having been informed and in agreement with the changes. Initial ____

4. Removal of Teeth:
Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, ect.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand 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 (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. Initial ____

5. Anesthesia:
I realize the risks involved in receiving an anesthetic, some of which are: upset stomach, dizziness, vomiting, sore arm, inflamed vessels of the area. Adverse reactions to the drugs causing cardiac arrest, miscarriage, dislodging or chipping teeth and jaw bone. Initial ____

6. Crowns, Bridges and Caps:
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further 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. Initial ____

7. Dentures- Complete or Partial:
I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Initial ____

8. Endodontic Treatment (Root Canal):
I realize there is no guarantee that root canal treatment will save my tooth and that complication can occur from the treatment and that occasionally metal objects are cemented to the tooth or extended through the root which does not necessarily affect the success of the treatment. Initial ____

9. Periodontal Loss (Tissue and Bone):
I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth and other complications. The alternative treatment plans have been explained to me including, gum surgery, replacements and or extractions. I understand that although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, treated teeth may require extraction. Initial ____

10. Fillings:
I have been advised by the Dentist that the silver amalgam restoration is an acceptable procedure according to ADA guidelines and, as such, is a treatment used by Friendly Smiles Dental Group. The advantages and disadvantages of alternative materials have been explained to me. Initial ____

I hereby request and authorize the Dentist and their Staff to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissue, as explained above.
The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.
I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have requested and authorized. I also understand that it is my responsibility to inform the Dentist if I am having any problems during the following treatment so as to allow him to help minimize the problems.

Initial ____

Alternative and possible reactions have been explained to me clearly and in detail. Complications, such as infection, hemorrhage and or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues, fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE BEEN AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, ANYTHING I DID NOT UNDERSTAND AND HAS BEEN EXPLAINED TO ME.

Signature_____ Relationship_____ Date_____

Doctor_____ Witness_____ Date_____