Pacific Beach Dentistry

GENERAL DENTISTRY INFORMED CONSENT **NAME**___________________________

1. Exam, X-Rays, Drug Administration. I authorize the Dentist to provide a comprehensive oral examination and to take any/all x-rays deemed necessary by the Dentist to properly diagnose and plan treatment. I consent to the proposed dental treatment explained to me by the Dentist. I understand that it may be necessary to change or add procedures because of conditions found during treatment that were not discovered during examination. I authorize the Dentist to make any/all changes necessary. I understand that antibiotics, analgesics, and other medications can cause allergic reactions resulting in redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that there are risks associated with receiving local anesthetic, such as persistent numbness (parasthesia) and bruising (hematoma), which while rare, can occur.
(Initials_______)

2. Restorations (Fillings). I understand that a more extensive filling, a crown, or root canal therapy beyond that originally diagnosed may be required due to additional decay or fracture. I understand that significant sensitivity can be a common occurrence after the placement of a new filling.
(Initials_______)

3. Crowns and Bridges (Caps). I understand that sometimes it is not possible to match the color of artificial teeth *exactly* with natural 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 maintained until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crowns or bridges (shape, size, fit, color) will be *before* cementation. It is my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement and necessitate a remake of the crowns or bridges at an additional cost to me. I understand that significant sensitivity can be a common occurrence after cementation of a new crown. **(Initials_______)**

4. Periodontal Disease (Gums and Bone). I understand that I have a serious condition that causes gum and bone inflammation and destruction and that it can lead to the loss of my teeth. I understand that scaling and root planning and any adjunctive therapy provided by the Dentist is a treatment of periodontal disease and not a cure. I understand that progression of my periodontal disease may require further treatment by a specialist.
(Initials_______)

5. Endodontic Treatment (Root Canal Therapy). I realize that there is no guarantee that root canal therapy will save my tooth. I understand that complications can occur from treatment, such as perforation of the tooth or root, or separation of an instrument, which may require further treatment by a specialist. I understand that 5-10% of root canal therapies fail, necessitating re-treatment, surgery (apicoectomy) or extraction. I understand that a crown is usually recommended for any tooth following root canal therapy to prevent breakage or fracture and the possible loss of my tooth.
(Initials_______)

6. Extractions (Removal of Teeth). Alternatives to removal have been explained to me and I authorize the Dentist to remove the specified teeth. I understand that removing teeth does not always remove all of the infection and that it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling/bruising, excessive bleeding, injury to adjacent teeth, spread of infection, dry socket, sinus perforation, fractured jaw, or persistent numbness (parasthesia) that can last for an indefinite period of time. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.
(Initials_______)

7. Complete/Partial Dentures. I understand that wearing dentures is difficult. Sore spots, altered speech and taste, and difficulty eating are common problems. Immediate dentures (placement of denture immediately following extractions) may be painful. Immediate dentures may require considerable adjustments and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitting dentures.
(Initials_______)

I understand that dentistry 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 dental treatment, which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I hereby authorize any of the doctors to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. Should any dispute arise over dental services provided to me, that is whether any dental service rendered was allegedly unnecessary, unauthorized, or was improperly, negligently, or incompetently performed, said dispute will be submitted to Peer Review by the local component of the American Dental Association. The decision of Peer Review shall be binding on both parties. **I acknowledge that I have received a copy of The Facts about Fillings sheet.** I have read, understood and agreed to the above.

SIGNATURE ____ **DATE**____________________
DENTIST_______________________________ **WITNESS**_______________________________