INFORMED CONSENT TO TREATMENT

Patient Name:____

EXAMINATIONS AND X-RAYS
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the treatment plan

(Initials______)

DRUGS, MEDICATION AND SEDATION
I have been informed and understand that 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). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I inform my Dentist of all the medications I am currently taking.

(Initials______)

CHANGES IN TREATMENT
I understand that during the 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. For example, root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and/or additions necessary

(Initials______)

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
I understand that popping, clicking, locking and pain can intensify and/or develop in the joint of lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in open position. Although symptoms of TMD associated with dental treatment are usually temporary and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials______)

DENTAL PROPHYLAXIS
I understand that the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials______)

NITROUS OXIDE
I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side-effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials______)

DENTAL BENEFITS
I understand that my insurance may provide only the minimum standard care. I understand that submitting insurance and receiving benefit is my responsibility. I elect to follow the Dentist's recommendations for optimal treatment. I understand that regardless of any dental insurance coverage which I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collection fees or court costs that may be incurred to satisfy my obligation to this office.

(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 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 also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand postoperative instructions and have been given an appointment date to return (as applicable).

____ ____________________
(Patient Signature) (Date)

____ ____________________
(Doctor Signature) (Date)