DUBLIN PLAZA DENTAL

General & Cosmetic Dentistry For All Ages

INFORMED CONSENT FORM

Patients Full Name:_____

I. Diagnostic Services

I understand that proper evaluation my dental condition and needs requires a combination of visual exam, x-rays, and tests. I agree to receive any required diagnostic services where appropriate to help determine my dental needs.

Initial_____.

II. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions, eg. redness and swelling of the tissues, pain, itching, vomiting, and/or anaphylactic shock. It is my responsibility to let doctor know of any allergies or history of adverse reactions to any medications I've had before.

Initial_____.

III. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions that where not evident during the initial examination but where found after starting treatment. I give my permission to the Dentist to make any and all changes/additions as he sees necessary. These changes will be discussed with me whenever they occur.

Initial_____.

IV. Removal of Teeth

Alternatives to removal have been explained to me and I authorize the Dentist to remove treatment-planned teeth and any others necessary for reasons in paragraph III. I understand removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed and 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.

Initial_____.

V. Crowns, Bridges, and Veneers

I understand that sometimes it may not be possible to match the color of artificial teeth exactly to natural teeth. I further understand that I may be wearing temporary restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent restorations are delivered. Often teeth need/have large fillings in conjunction; see VIII below. I realize the final opportunity for me to make changes to my new crown, bridge, or veneer (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation about two weeks from tooth impression as scheduled. Excessive delays may allow for tooth movement. This may necessitate a remake of the restoration altogether. I understand there will be additional charges for remakes due to my delaying permanent cementation or failure to comply with care instruction for the temporaries.

Initial_____.

VI. Endodontic Treatment

I realize there is no guarantee that a root canal treatment will save my tooth; and that complications can occur from the treatment, and root canal filling material may extend beyond the tooth/root, which does not necessarily affect the success of treatment. I understand that endodontic files and instruments are very fine tools… stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures and/or referral to a specialist may be necessary following root canal treatment, the cost of which is my responsibility. I understand the tooth may be lost despite all reasonable efforts to save it.

Initial_____.

VII. Periodontal / Gum Treatment

I understand that gum disease is a serious condition causing gum & bone inflammation or loss; and it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including prophylaxis OR deep cleaning, surgery, gum replacements, specialist consultation, and/or extractions. I understand that not undertaking necessary dental procedures may have a future adverse affect on my periodontal condition. Any dental work received now can impact status of my periodontal condition. I understand that following the Dentist recommended treatment regimens & home care instructions will play a very important role in the success of my treatment and overall health.

Initial_____.

VIII. Fillings

I understand that care must be exercised in chewing on (silver amalgam) fillings especially during the first twenty-four hours to avoid breakage. I understand that sensitivity is a common after-effect of a newly placed restorations, but it is almost always temporary. However, I understand that deeper/larger restorations can sometimes lead to irreversible nerve inflammation (sensitivity), which may require additional treatment (such as root canal).

Initial_____.

IX. Dentures

I understand the wearing of dentures is difficult. Sore spots, altered speech / taste, difficulty in eating, and denture mobility are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may need several adjustments and relines. A permanent reline will be needed later; this is not included in the denture fee. I understand it is my responsibility to return for delivery of the dentures as scheduled. I understand that failure to keep my appointment may result in poorly fitting dentures. If a remake is required due to my delays of more than thirty days, there will be additional charges.

Initial_____.

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot realistically guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding my dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment. I hereby authorize the treating dentist (or dental auxiliary where appropriate) to proceed with and perform the dental restorations and treatments as explained to and accepted by me. I understand that quoted treatment fees and insurance/patient portions are only an estimate and subject to modification depending on unforeseen or un-diagnosable circumstances that may arise during the coarse of treatment. I understand that regardless of any dental insurance coverage that I may have, I am responsible for payment of dental fees for services rendered. I agree to pay any attorneys fees, collection fees, or court costs that may be incurred by the dental office to satisfy this obligation.

Patient /Guardian Signature_____Date_____

Doctor Signiture_____Date_____