SATO FAMILY DENTAL

GENERAL DENTISTRY INFORMED CONSENT

Patient Name : _____

1 **EXAMINATIONS AND X-RAYS**
I understand that initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

(Initials)

2 **DRUGS,MEDICATIONS 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). They may cause drowsiness and 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 office for my care. I understand that failure to take medications prescribed to me may offer risks of continued or aggravated infection and pain and potential resistance to effects treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

(Initials)

3 **CHANGES 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 or all changes and additions as necessary.

(Initials)

4 **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**
I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment where in the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature 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, and the cost of which is my responsibility.

(Initials)

5 **FILLINGS**
I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid brekage. I understand that sensitivity is a common after-effect of a newly placed filling.

(Initials)

6 **REMOVAL OF TEETH**
I understand that alternatives to removal (ex: root canal therapy, crowns and periodontal surgery, etc.) will be explained to me at the time of tooth removal and I authorize the Dentist to remove the 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 or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials)

7 **CROWNS, BRIDGES, CAPS, VENEERS AND BONDING**
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. I realized that the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be done before cementation. I understand that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

(Initials)

8 **DENTURES-COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. I understand that looseness and possible breakage may become a problem of wearing the denture appliances. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement.

(Initials)

9 **ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally metal objects are cementated in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials)

10 **PERIODONTAL TREATMENT**
I understand that serious condition of periodontal diseases may cause gum inflammation and/or bone loss and that it can lead to the loss of teeth. I understand there are alternative treatment plans, including non-surgical cleaning, gum surgery and/or extractions in the case of necessary perio treatment. I understand the success of an treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a health diet, avoid tobacco products and follow other recommendations.

(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 also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment. I acknowledge and understand the post-operative instructions written on this General Dentistry Informed Consent form have been given an appointment date to return.

Signature: _____ **Date:** _____

Doctor: _____ **Witness:** _____