Mission Viejo Dental Associates

GENERAL DENTISTRY INFORMED CONSENT

CHART # _____

NAME _____

1. **WORK TO BE DONE**

I understand that I am having the following work done: Fillings ____, Bridges ____, Crowns ____, Extractions ____, Impacted Teeth Removed ____, Sedation ____, Root Canals ____, Periodontal ____, Full Mouth X-Rays _____, Other _____.

(*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) and they can cause pain, thrombophlebitis (inflammation of a vein) from intravenous and intramuscular injections, injury to and stiffening of neck and facial muscles. 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 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. (*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/all changes and additions as necessary. (*Initials* _____)

4. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) 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 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* _____)

5. **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 realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape fit, size and color) will be before cementation. It has been explained to me, in a very few cases, cosmetic procedures may result in 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* _____)

6. **DENTURES - COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. 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. The cost for this procedure is not included in the initial denture fee. (*Initials* _____)

7. **ENDODONTICS 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 cemented in the tooth or extended through the root which do not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (*Initials* _____)

8. **PERIODONTAL LOSS (TISSUE & 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. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition. (*Initials* _____)

9. **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 wherein 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 arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. (*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 neither Mission Viejo Dental Association nor any Dentist other than the treating Dentist is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: _____ Date: _____

Doctor: _____ Witness: _____