

Patient: Please complete 1 - 5 and 6 - 11 as needed.

1. **EXAMINATION AND X-RAY:** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plans. **INITIALS:** _____
2. **DRUGS, MEDICATIONS, AND SEDATION:** I have been informed and understand that antibiotics and 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 & lack of awareness & coordination which can be increased by the use of alcohol or other drugs. I understand & 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, & 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 & potential resistance to effective 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 me permission to the Dentist to make any/all changes and additions if necessary. **INITIALS:** _____
4. **TEMPOROROMANDIBULAR 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 for treatment arise, that I will be referred to a specialist for treatment, and the cost of which is my responsibility. **INITIALS:** _____
5. **DENTAL MATERIAL FACT SHEET:** I acknowledge that I have read the Dental Material Fact Sheet. **INITIALS:** _____
6. **FILLINGS:** I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling. **INITIALS:** _____
7. **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 other necessary for reasons in Item #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, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time of 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:** _____
8. **CROWNS, BRIDGES, CAPS, VENEERS & 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 that in a very few cases, cosmetic procedures may result and affect the need for future root canal treatment which cannot always be predicted or anticipated. I understand cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. **INITIALS:** _____
9. **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 to my new denture (including shape, fit, size, placement, and color) will be the "teeth in way" 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:** _____
10. **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 cemented 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:** _____
11. **PERIODICAL TREATMENT:** I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. **INITIALS:** _____

I understand that dentistry is not an exact science and that therefor 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 any other Dentist 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.

Patient Signature: _____ **Date:** _____

Doctor Signature : _____ **Date:** _____

