GENERAL DENTISTRY INFORMED CONSENT

PATIENT'S NAME: _____ **DOB** _____

1. 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 attached treatment plan. **Initials** _____

2. DRUGS, MEDICATION AND SEDATION: I 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). 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 fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the medication. I understand that failure to take medications as prescribed to me 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 or oral contraceptives (birth control pills). **Initials** _____

3. LOCAL ANESTHESIA: I understand that local anesthesia may cause injury to nerve that may result in pain, prolonged or permanent numbness, tingling or other sensory disturbances of the chin, lips, cheeks, gums, bone or tongue. These situations may persist for several weeks, months or be permanent. It is administrated with a very small fine needle, in rare instances these needles may break off and may be lodge inside of my oral tissues. The anesthetic may cause dizziness, nausea, vomiting, accelerated heart rate, slow heart rate or various types of allergic reactions. Any or all these may require additional medical management or hospitalization. **Initials** _____

4. 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** _____

5. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD): I understand that 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, then I will be referred to a specialist for treatment, the cost of which is my responsibility. **Initials** _____

6. DENTAL PROPHYLAXIS (CLEANING): I understand the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. I understand bleeding could last several hours. If it persists, particularly if it is severe in nature, it should receive attention and this office must be contacted. **Initials** _____

7. FILLINGS: I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. 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** _____

8. REMOVAL OF TEETH: Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth in my original treatment plan scanned in my file. If in the future more teeth need to be removed I will consent to treatment at that moment. 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, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that 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** _____

9. CROWNS, BRIDGES, VENEERS AND BONDING: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I know 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 veneer (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 in the need for future root canal treatment, which cannot always be predicted or anticipated. Cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. If that's the case there will be additional charges for remakes or other treatment due to my delaying permanent cementation and I will fully responsible of paying them. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge**.** **Initials** _____

10. 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. 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. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A second set of dentures will be necessary later in some cases and this new set is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for the reline is not included in the initial denture fee. I know that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges. **Initials** _____

11. ENDODONTIC TREATMENT (ROOT CANAL / RCT): I realize there is no guarantee that RCT will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The overall rate of success is 92%. The tooth may be sensitive during treatment and even remain tender for a time after RCT. Hard to detect root fracture is one of the main reasons RCT fails. Since teeth with RCT are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following RCT (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. **Initials** _____

12. BLEACHING: is a procedure done either in office (1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience teeth sensitivity and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment **Initials** _____

13. 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** _____

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 post-operative instructions and have been given an appointment date to return. This form was explained to me in my own mother language and a translator was present. I hereby authorize any of the doctors and Clinical staff members of GDC Smiles (Gallo Dental Care, LLC) to proceed with and perform the dental treatment plan explained to me.

Patient's Signature _____ Date: _____

Witness' Signature_____ Witness' Name_____ Date: _____

Dentist's Signature _____ Date: _____