HOPE FAMILY DENTISTRY

Patient Name: _____ Chart #: _____

_____ 1. WORK TO BE DONE

I understand that I am having the following work done Fillings, Bridge, Crowns/SSC, Extractions, Exam & X-rays, Root Canal/ Pulpotomy, Dentures/Partials, Periodontics, Cleaning, Etc.

_____ 2. DRUGS AND MEDICATIONS

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)

_____ 3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give permission to the dentist to make those changes as necessary.

_____ 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: _____. 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 (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

_____ 5. ANESTHESIA

I realize that risks involved in receiving an anesthetic, some of which are upset stomach, dizziness, vomiting, sore arm, inflamed vessels of the arm, adverse reactions to drugs causing cardiac arrest, miscarriage, dislodging or chipping teeth and jaw bone.

_____ 6. CROWNS, STAINLESS STEEL CROWNS, BRIDGES, CAPS ONLAY

I understand that sometimes it is no 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.

_____ 7. DENTURES- COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change.

_____ 8. ENDODONTIC TREATMENT, RE-TREAMENT, PULPOTOMY

I realize there is **NO GUARANTEE** that root canal, pulpotomy 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.

_____ 9. 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 and other complications. The alternative treatment plans have been explained to me, including gum surgery, replacements and/extractions. I also understand that although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, teeth treated may require extraction.

_____ 10. FILLINGS

I have been advised by the dentist that the silver amalgam restoration is an acceptable procedure according to ADA guidelines and, as such, is the treatment used by Hope Family Dentistry. The advantage of alternative materials has been explained to me.

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve any appearance, function, and health of my mouth, teeth, bone, and tissues, as explained above.

The effect and nature of the proceeding to be performed, and risks involved, as well as possible alternative methods of treatment have fully been explained to me. I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable to attempting to improve the condition stated on the diagnostic treatment from or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of the Dentistry and Surgery 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 treatment which I have herein requested and authorized.

_____ I also understand that is my responsibility to inform the dentist if I am having any problem during or following treatment so as to allow him to help minimize any problem.

_____ Alternative and possible untoward reactions have been explained to me in detail and clearly. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate reaction to any drugs before. During and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Paresthesia), fractured jaw etc. have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

SIGNATURE: _____ RELATHIONSHIP: _____ DATE: _____

DOCTOR: _____ DATE: _____