STATEMENT OF CONSENT FOR AMALGAM REPLACEMENT PROCEDURES

1. I hereby authorize Dr. _____________________ and/or other dentists or assistants as may be selected by him/her to treat my condition(s). The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure as follows: ................................................................................................................................................

2. I have been informed of my current dental diagnosis and of possible alternative methods of treatment (if any).

3. I further understand that this is an elective procedure that other forms of treatment or no treatment at all are choice that I have, and I have discussed the known risks of these other forms of treatment with my dentist.

4. I understand that replacement of dental amalgam in a non-allergic patient does not indicate that the doctor is of the opinion that amalgam is a health hazard.

5. The doctor has explained to me that there are certain inherent and potential risks in ANY treatment plan or procedure. We do not expect these to occur, but there is that possibility. In this specific instance such risks include, but are not limited to, the following:
   A. Nerve inflammation leading to hot and cold sensitivity
   B. The need for endodontic therapy (root canal treatment)
   C. Cracked cusps
   D. A shorter length of serviceability of the restoration with the need for more frequent replacement
   E. In cases where the previous restorations (fillings) are very large, the use of cast or full coverage crowns, or bonded porcelain are suggested

6. It has been explained to me that, during the course of the procedure(s), unforeseen conditions may be revealed that necessitate and extension of the original procedures or different procedures(s) than those set forth in paragraph 1 above. I, therefore, authorize and request that the persons described in paragraph 1 above perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph 6 shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

7. I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described in paragraph 1, and to the use of such anesthetics as may be advisable with the exception of: _____________________________ to which I said I was allergic. I recognize that there are always risks to life and health associated with anesthesia and such risks have been explained to me.

8. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device until I have recovered from the effects of the anesthetic medication and drugs that I may have been given in the office for my care.

9. It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

10. I agree to cooperate completely with the recommendations of the doctor while I am under his/her care, realizing any lack of same could result in a less than optimum result and that failure to follow the doctor=s suggestions and directions could be even life threatening.

11. I have been given ample opportunity to ask questions and any questions I have asked have been answered in a satisfying manner.

12. I certify that I read and write English and fully understand this consent. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT.

____________________________________ _________________
Signature Date

____________________________________ _________________
Witness Date

____________________________________ _________________
Dentist Date
INFORMATIONAL PURPOSES ONLY

APICOECTOMIES AND APICAL SURGERY

I UNDERSTAND that APICOECTOMIES include possible inherent risks such as, but not limited to the following:

1. Injury to the nerves: This would include injuries causing numbness of the lips, the tongue, any tissues of the mouth; and/or cheeks or face. This numbness could occur and may be of a temporary nature, lasting a few days, a few weeks; a few months; or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.

2. Bleeding, bruising, swelling: Bleeding may last several hours. If bleeding is profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time.

3. Infection: No matter how carefully surgical sterility is maintained, it is possible, due to existing non-sterile or infected oral environment, infections may occur postoperatively. At times, infections may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon possible should be received.

4. Sinus or Mandibular Canal Involvement: In some cases, the roots of the teeth that are going to be apically treated lie in closer apposition to the Maxillary Sinuses or to the Mandibular Canal, including the Mental Foramen than they appear to be radiographically. Even though a rare occurrence, there is a slight possibility that the Maxillary Sinus or the Mandibular Canal may be perforated, or the nerves emanating from the Mental Foramen may be traumatized during the surgical procedure involved with removing the apices of the infected teeth.

5. Injury to adjacent teeth or adjacent roots: There is a possibility of injury to an adjacent tooth or to roots of teeth during the procedure. If an adjacent tooth or roots of teeth are inadvertently nicked or otherwise damaged during the surgical procedures, conventional endodontic treatment, endodontic surgery, or extraction may be required.

6. Bacterial Endocarditis: Because of normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and Bacterial Endocarditis (an infection of the heart) could occur. Pre-existing conditions causing valvular dysfunction are the most likely cause of this complication. It is my responsibility to inform the dentist of any heart problems known or suspected.

7. Failure: Even though the surgical procedure is properly performed, there exists the possibility that the attempt to preserve the tooth will fail due to the tooth and tissues not responding as they should, thereby necessitating extraction of the tooth.

8. Unusual reactions to medications given or prescribed: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics that may be necessary to control infection can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.

9. It is my responsibility to seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given me.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment known as Apicectomies and have received answers to my satisfaction. I have been given the option of seeking care from any oral-maxillofacial surgeon; a periodontist; and/or endodontist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorized Dr. ______________________ and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient=s name (please print) ______________________ Signature of patient, legal guardian or authorized representative ______________________ Date ______________________

Tooth No.(s) ______________________

______________________________
Witness to Signature

______________________________
Date
APPLIANCE RELEASE AND PAYMENT AGREEMENT

The appliance being made for my child is a temporary appliance used to maintain proper tooth space or to provide better aesthetics or both.

Release
I understand that if my child does not have periodic examinations, problems may occur to the teeth to which the appliance attaches. For example, a band may become loose, which may cause tooth decay or other problems if left unattended. I agree not to hold Dr. ______________ responsible for any problems or additional treatment cost arising from such problems. I acknowledge that it is my responsibility to see to it that Dr. ______________ is notified of any problems or concerns of which I become aware regarding the appliance or instructions for its use and that Dr. ______________ is not responsible for matters arising from any failure to keep him informed.

Payment Agreement
I will pay $________ at the initial appointment at which impressions will be taken for the appliance. I will pay the balance, less any amount for which there is insurance coverage, when the appliance is delivered. I also agree that after impressions have been taken for the appliance, I will be responsible for the total cost of the appliance even if I choose not to have the appliance placed.

I have read and fully understand this Appliance Release and Payment Agreement.

__________________________
Date  ____________________________ (Signature of parent)
INFORMATIONAL PURPOSES ONLY

BLEACHING TEETH
OUTSIDE THE DENTAL OFFICE

Hydrogen peroxide has been used for many years to bleach teeth. In the past, application of hydrogen peroxide was usually accompanied with heat and/or light. Recently peroxide has been applied to teeth in trays at home, supervised by patients. This technique does not require heat or light. Although the results of the procedure do not appear to be different from more traditional techniques, a few potential reversible negative events are described below. Also, as with other forms of tooth bleaching, occasionally upgrade bleach applications may be necessary in future years.

**Patient instructions (nighttime use only)**
1. At bedtime, brush and floss teeth. Rinse mouth well.
2. Place 2-3 drops of bleaching gel into each space in the tray for every tooth to be lightened.
3. Insert tray into mouth over teeth, expectorate excess gel, and wear loaded tray during sleep every night.
4. Rinse tray each morning, and clean teeth as usual. Fluoride-containing toothpaste and mouth rinse may be used if desired.
5. Discontinue bleach if tooth sensitivity, gum irritation, or any other negative event occurs. Notify your dentist with the problem immediately.

The average time for optimum color change to occur using nighttime bleaching technique is six weeks, although effects may be noticed as early as two weeks. Observation appointments are necessary every 7-10 days to check the progress of the bleaching.

**Patient instructions (increased bleach time)**
1. In addition to using the bleaching trays each night, you may decrease the time necessary for your bleach by applying the solution in your trays up to several 2-hour periods daily.
2. An ideal additional time for many persons is the two hours before retiring.
3. Total bleaching time per day, including the 7 or 8 hours during sleep, should not exceed 18 to 20 hours. Most patients find that 1-3 total periods per day (including night) is not objectionable.

I HAVE READ AND UNDERSTAND THE ABOVE DIRECTIONS AND CAUTIONS:

_______________________________________________  __ ______________________
Signature        Date
INFORMATIONAL PURPOSES ONLY

ROOT CANAL THERAPY

I UNDERSTAND that ROOT CANAL THERAPY includes possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of results have been made nor are expected:

1. The teeth treated may remain tender or even quite painful for a period of time, both during and after completion of treatment. If pain is severe or swelling occurs, please call our office immediately. There is also a possibility of numbness occurring and/or persisting in the tongue, lips, teeth, jaws and/or facial tissues which may be a result of the anesthetic administration or from treatment procedures. This numbness is usually temporary, but, rarely, could be permanent.

2. In some teeth, conventional root canal therapy may not be sufficient. If the canals are calcified, roots are excessively curved or inaccessible, inadvertent pulp chamber or root perforation may occur, requiring referral to a specialist. If there is infection in the bone surrounding the tooth, referral to a specialist for extraction or a surgical Apicoectomy may become necessary.

3. Root canal treated teeth must be protected. During and after treatment, your tooth in most instances will have only a temporary filling. Should this come out, please call us for a replacement. It is advisable to crown or cap a tooth as soon as possible after root canal treatment. Root canal treated teeth may become brittle and, due to undermined or reduced tooth structure, leave the teeth subject to cracking or fracturing. Crowning or capping the treated tooth or teeth is the best precautionary measure to help avoid this from occurring.

4. Root canal therapy is not always successful. Many factors influence success: adequate gum tissue attachment and bone support; oral hygiene; previous and present dental care; general health; trauma; pre-existing, undetected root fractures, accessory or lateral canals, etc. Even though a tooth may have appeared to be successfully treated, there is always the possibility of failure making additional root surgery (Apicoectomy) or extraction necessary. If a bridge abutment or crowned tooth requires endodontic therapy, the chance of perforation is enhanced due to obscured anatomy.

5. A crown abutment or crown (cap) may be damaged or destroyed during rubber dam application, access preparation, or other procedures as part of endodontic therapy. Porcelain is particularly susceptible to fracture or cracking, and an existing porcelain cap may have to be remade, particularly if the pre-existing cap is all porcelain in design.

6. Root fracture is one of the primary reasons for root canal failure. Unfortunately, hairline cracks are almost always invisible and undetectable. Causes of root fracture are trauma, inadequately protected teeth, cracking of the tooth, large fillings, improper bite, excessive wear, habitual grinding of teeth, etc. Root fracture after or prior to treatment usually necessitates extraction.

7. There are alternatives to root canal treatment. These alternatives (though not of choice) include: no treatment; extraction; extraction followed by bridge or partial denture placement; and/or extraction followed by implant and crown placement.

8. Because of the fragility and small diameter of root canal instruments used in root canal treatment, there exists the possibility of instrument separation (breakage) which may or may not be detected at time of treatment.

9. Medications. Analgesics and/or antibiotics may need to be prescribed depending on symptoms and/or findings. Prescription drugs must be taken according to instructions. Women on oral contraceptives must be aware that antibiotics cause these contraceptives to be ineffective. Other methods of contraception must be utilized during the treatment period.

10. ONCE TREATMENT IS BEGUN, it is absolutely necessary that the root canal treatment must be completed. One or more appointments may be required to complete treatment. It is the patient’s responsibility to seek attention should any unanticipated or undue circumstances occur. Also, the patient must diligently follow any and all preoperative and/or postoperative instructions given by the dentist and/or staff.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I have been given the option of seeking this treatment from a specialist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorized Dr. _____________________________ and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient’s name (please print) _____________________________ Signature of patient, legal guardian or authorized representative _____________________________ Date __________

Tooth No(s) _____________________________ Witness to Signature _____________________________ Date __________
CONSENT TO PERFORM ENDODONTICS

This authorization and consent for treatment is given to Dr. ______________________ and staff after first having had a full explanation of the proposed treatment. This disclosure is not meant to frighten me. It is simply an effort to make me better informed so I may give or withhold my consent.

The doctor has explained that his/her diagnosis is ____________________________ and has advised me than in his/her opinion root canal treatment is indicated. The doctor has advised me in his/her opinion and the consequences of not treating this condition include but are not limited to: worsening of the disease, infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease manifestations. The doctor has advised me of alternative treatments, benefits, and risks which include are not limited to: extraction of the infected tooth (teeth) or not treatment or referral to a specialist (endodontist). I, however, believe that the root canal as noted above would be my preferred choice of treatment.

The doctor has advised me that there are certain risks and potential consequences of any treatment and such risks would include but are not limited to:

$ A certain percentage (approximately 5-10%) of root canals fail, necessitating re-treatment, root surgery (with a referral to a specialist), or extraction.

$ Postoperative discomfort, swelling, restricted jaw opening which may persist several days or longer.

$ Breakage of root canal instrument during treatment which may, in the judgement of the doctor, be left in the treated root canal or require surgery by a specialist for removal.

$ Perforation of the root canal with instruments which may require additional surgical corrective treatment by a specialist or result in loss of tooth.

$ Premature loss of tooth due to progressive periodontal (gum) disease.

$ Root canal treatment relies heavily on radiographic information. Since radiographs are essentially 2-dimensional shadows which provide reliable but not infallible information, this may lead to root canal failures.

$ Successful completion of the root canal procedure does not prevent future decay or fracture. The endodontically treated tooth will be more brittle and may discolor.

$ In most cases, a crown and post filling is recommended after completion of the root canal to prevent fracture and/or improve esthetics.

The endodontic fee is $__________ and does not cover alloy, plastic restoration, or crown.

I have read and understand the above and had all my questions answered to my satisfaction. I agree to proceed with the recommended root canal therapy.

________________________________________  ____________________
Patient=s Name (printed)     Date

________________________________________
Patient=s Signature
What is root canal therapy and what are its benefits?
Root canal therapy is the procedure of cleaning out deeply decayed or infected tissue from inside the tooth followed by filling of the canal(s) or hollow tube(s) that remains once the tissue is cleaned out. It is the option offered when extracting or pulling the tooth and is oftentimes the only alternative. Root canal therapy allows the tooth to remain in the mouth and contribute to a sound, healthy and functional dentition for many years, if not a lifetime.

What are the possible complications of treatment?
With a success rate that is in the 90-95% range, endodontics is one of the most reliable dental or medical procedures. However, there can be no absolute guarantee regarding treatment success. Some complications can include:

1. Possibility of perforations of the tooth’s crown or root. This can ultimately lead to surgical treatment by a specialist, or possible loss of the tooth.
2. Damage to existing restorations (fillings or crowns) which may necessitate replacement at the patient’s expense.
3. Possibility of the separation or breaking of instruments which may not be removable, and which may cause pain, swelling, and/or infection, which may result in the loss of the tooth.
4. Root canal treatment relies heavily on radiographic (x-ray) information. Since radiographs are essentially two dimensional images of a three dimensional object, they provide good but not infallible information about the shape of the tooth, which can lead to endodontic failure, which may necessitate re-treatment or surgical treatment at a specialist’s office.
5. Host resistance. In much the same manner that some people catch a lot of colds, some people’s immune systems are not as strong as others, which can contribute to endodontic failure due to persistent infection.
6. Some teeth have very calcified (narrow) or curved canals that may not allow for endodontic therapy to be completed to the end of the root. This may necessitate the future need for surgery by a specialist, or loss of the tooth. Sometimes a general dentist will refer a patient to a specialist if he/she finds a that they cannot successfully get instruments to the end of the root. If that occurs, you will be informed by your dentist, and no fee higher than a pulpotomy fee (a procedure where just the top part of the nerve tissue is taken out in emergencies and certain other instances) will be charged to the patient.
7. Some teeth may have fractured roots that are undetectable at the time of treatment. Unfortunately, this usually results in loss of the tooth.

IN ANY OF THE ABOVE CIRCUMSTANCES WHERE A SPECIALIST’S SERVICES ARE NEEDED, IT IS UNDERSTOOD THAT IT IS THE PATIENT’S RESPONSIBILITY FOR PAYMENT OF FEES AT THAT SPECIALIST.

8. Despite all efforts by a general dentist, or a specialist, some complications could result, which include, but are not limited to:
   1. allergic reactions to medications, materials, or drugs used;
   2. pain;
   3. swelling;
   4. infection;
   5. sensitivity to pressure during or after the canal(s) is sealed;
   6. paresthesia or long-term numbness.
13. Successful completion of a root canal does not prevent further decay or fracture. The treated tooth will need subsequent treatment with a permanent filling, or a crown buildup and crown, or a post and crown, depending on the individual tooth. The costs for doing any of these procedures are not included in the fee for performing a root canal.

What alternatives are there?
1. You can do nothing. This isn’t a very good option for very long, and is not recommended, but choosing not to have a problem dealt with is a patient’s right.
2. You can have the tooth extracted. This leaves a space which may be unacceptable due to cosmetics, phonetics (speech) and the possibility of other teeth moving into that space, causing problems with occlusion (your bite) or possibly exacerbating a gum-disease problem. That space can

I have read and understand the above and had all my questions answered to my satisfaction. I agree to proceed with the recommended root canal therapy.

________________________________________  ____________________
Patient’s Name (printed)     Date

________________________________________
Patient’s Signature
INFORMATIONAL PURPOSES ONLY

PATIENT CONSENT FOR ENDODONTIA
(Root Canal Therapy)

I fully understand that because of my dental problems, which are: .............................................................................., root canal therapy is indicated. I understand the reasons for treatment which can be the removal of infection or the exposed nerve end to prevent re-infection.

GENERAL INFORMATION
Endodontics is a branch of dentistry concerned with diagnosis, treatment, and prevention of diseases of the dental pulp and its surrounding tissues. Root canal therapy is performed on a tooth that is infected or if the nerve has been exposed due to pulpitis (inflammation of the pulp of a tooth), abscess (a localized collection of pus), prosthetics reasons, or failed previous treatment.

ALTERNATIVES
The alternative treatment of tooth extraction which is the removal of the tooth has been fully explained to me; as well as the option of no treatment. The possible results if no treatment is performed have been fully explained to me. I also understand the possible consequences of not completing endodontic treatment once it is initiated.

SYMPTOMS AND RISKS
I understand that during or after endodontic treatment there is a possibility the following may occur: pain, swelling, infection, reinfection, cold sores, canker sores, irritation or injury to the oral mucosa, periodontal involvement (loss of bone and tooth mobility due to infection), breakage of instruments (such as files) within the root canal of the tooth, calcified canals preventing endodontic therapy through the entire length of the root, perforation of the crown or root of the tooth (by dental instruments or as a pre-existing condition), allergic reactions to dental materials or medications.

SUCCESS
I also understand that root canal therapy is not 100% successful and that the endodontic procedure may have to be repeated and/or an additional minor surgical procedure may be required. The success rate is between 85% and 95%. I understand that the treatment will involve several appointments to complete the procedure. I understand the benefit of saving a tooth which might otherwise need extracting.

I UNDERSTAND THAT AFTER ENDODONTIC TREATMENT, the tooth will require restorative treatment. I understand that although root canal treatment can save the tooth, the procedure weakens the tooth and causes the tooth to become more brittle, turn dark in color, and more susceptible to fracture. Therefore, the tooth should have a crown or porcelain inlay/onlay restoration upon completion of the endodontic treatment.

I HEREBY CERTIFY THAT I FULLY UNDERSTAND THIS AUTHORIZATION for endodontic treatment. I have been given the opportunity to ask questions and have been given satisfactory answers. I am aware that the practice of dentistry and endodontics is not an exact science, and I acknowledge that no guarantees have been made to me as a result of the procedures authorized above. I hereby authorize Dr. _______________________ and staff to perform examinations, diagnostic procedures and treat accordingly with root canal therapy.

________________________________________  _______________________________________
Date                                                                                   Patient’s Name (printed)      Witness (to signature only)

________________________________________  _______________________________________
Patient’s Signature                                                                 Witness (to signature only)
I hereby consent to the endodontic treatment procedure for myself (or my child ____________) on


tooth number(s) ________________ to be performed by Dr. __________________________. I

understand the nature of the problem causing the need for treatment (that the nerve tissue within the
tooth is dead or dying and causing acute or potential risk of infection in the bone surrounding the tooth),
and I understand the reasons for treatment (removal of the nerve tissue to relieve or prevent infection).
The alternative treatment of extraction of the tooth has been explained to me as well as the potential
consequences if no treatment is performed. I also understand the possible risks of not completing this
treatment once it is begun.

I understand that during or after endodontic treatment there is a possibility the following may occur:
pain, swelling, infection, reinfection, cold sores, canker sores, irritation or injury to the oral tissues,
periodontal involvement (bone loss and tooth mobility due to infection), calcified canals preventing
complete endodontic therapy, allergic reactions to dental material or medications, breakage of
instruments (such as files) within the root canal or perforation of the crown or root of the tooth (by
dental instruments or as a pre-existing condition) which may require surgical correction or result in the
loss of the tooth.

I understand that root canal therapy is not always successful (approximately 90-95% of cases are treated
successfully) and that the endodontic procedure may have to be repeated and/or an additional surgical
procedure may be required at additional expense. I understand that the treatment may involve several
appointments to complete, and I may loose this tooth despite all efforts to save it.

I understand that after endodontic treatment, the tooth will be more brittle, may discolor (possibly
requiring bleaching or veneering), and will require restorative treatment (filling, post, buildup, and/or
crown), and I have been given and estimate of fees for the completion of this work. Failure to complete
this restorative treatment may result in the loss of the tooth due to fracture. I have been given the
opportunity to ask questions and have received satisfactory answers. I am aware that the practice of
Dentistry and Endodontics is not an exact science, and I acknowledge that no guarantees have been made
to me as a result of the procedure authorized above.

________________________________             _____________________________________
Date                                           Signature of Patient (or person with authority to consent for patient)

________________________________             _____________________________________
Date                                           Signature of Dentist

________________________________             _____________________________________
Date                                           Signature of Witness
CONSENT FOR ENDODONTIC TREATMENT

I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.

I, the undersigned, have been informed of the alternatives to root canal treatment, including no treatment at all, I understand that if no treatment is provided I may experience:

1. The loss of the tooth;
2. Bone destruction due to an abscess.
3. Possible systemic (affecting the whole body) infection.

I also understand that if I choose to have root canal treatment for tooth no. _____:

1. A certain percentage (5-10%) of root canals fail, and they may require re-treatment, periapical surgery, or even extraction.
2. During instrumentation of the tooth, an instrument may separate and lodge permanently in the tooth, or an instrument may perforate the root wall. Although this rarely occurs, such an event could cause the failure of the root canal and the loss of the tooth.
3. A root can crack or split which may affect the outcome of the root canal therapy
4. When making an access (opening) through an existing crown or placing a rubber dam clamp, damage could occur and a new crown would be necessary after endodontic therapy.
5. Successful completion of the root canal procedure does not prevent future decay or fracture.
6. Temporary fillings are usually placed in the tooth immediately after the root canal treatment. Teeth which have had root canal treatment will require a permanent (outside) restoration. This may involve a filling or more extensive restorative work (pins, post, crown buildup, crown) depending on the clinical status of the tooth.

There are risks involved in administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the doctor of any previous side-affects of allergies from any medication.

Note: Antibiotics may decrease the effectiveness of birth control medication. Additional methods of birth control should be used while on antibiotics.

I agree that I have read, had explained to me and understand this consent for endodontic treatment. I have been given the opportunity to ask questions concerning the treatment, the risks of treatment and the alternatives to treatment. After fully considering this information, I hereby consent to endodontic treatment set forth above.

Date Patient or Patient's Guardian

Date Signature of Witness
Patient Name: __________________________

Informed Consent for Endodontic Treatment

1. On (date) __________________________, Dr. __________________________ discussed with me the following informed consent form for endodontic treatment of the condition(s) described below.

2. The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s) to be:

3. The prognosis for this(these) procedure(s) was described as:

4. I have been informed of possible alternative methods of treatment including:
   a) No treatment at all.
   b) Extraction
   c) __________________________

5. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive.
   a) swelling; sensitivity; bleeding; pain; infection;
   b) numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent;
   c) reactions to injections;
   d) changes in occlusions (biting); jaw muscle cramps and spasm; temporomandibular joint difficulty;
   e) loosening of teeth, crowns or bridges; or damage to existing restorations which may necessitate replacement of the restoration;
   f) referred pain to ear, neck and head; delayed healing; sinus performance;
   g) treatment failure; complications resulting from the use of dental instruments (broken instrument-perforation of tooth, root, sinus), medications, anesthetics and injections; discoloration of the face;
   h) reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effects of birth control pills.
   i) further treatment may be necessary.

6. It has been explained to me and I understand that the results of treatment is not guaranteed or warranted and cannot be guaranteed or warranted.

7. I have been given the opportunity to discuss this form and question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

8. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

Patient’s Signature __________________________ Date/Time __________________________

Doctor’s Signature __________________________ Date/Time __________________________

Witness’s Signature __________________________ Date/Time __________________________
ROOT CANAL THERAPY INFORMED CONSENT

I hereby give permission to ______________________________ to perform root canal therapy on my tooth no. ________, and such additional procedures as are considered necessary on the basis of findings during the course of said treatment.

I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require treatment, surgery or even extraction.

I also understand root canal therapy is a filling of the internal canal of the tooth and the final outside restoration will be necessary following the root canal filling. Since the blood supply is removed from the tooth, it has a tendency to become more brittle and may discolor so the usual restoration choice is a filling and a crown. A normal filling may suffice in some instances.

I understand that a series of appointments will be necessary to complete the root canal therapy, as well as other appointments for the final restoration. I am also aware that I may have continuing temporary symptoms throughout the treatment. Those symptoms may include:

1. Swelling
2. Pain
3. Infection
4. Drainage
5. Fever
6. Numbness

I understand that I should notify the dentist if any of these symptoms are present for more than 48 hours.

I consent for this procedure to be done with the following anesthesia and/or medications:

1. Local anesthesia only
2. Local anesthesia with oral preoperative sedative
3. Local anesthesia with nitrous oxide and oxygen

I also understand that the administration of anesthesia and/or medications carry certain inherent risks, such as, but not limited to:

1. Drug interactions and/or side effects
2. Bruising and/or numbness including the site of the injections

I acknowledge full responsibility for the payment of these services and agree to pay for them in full at or before completion, unless other specific arrangements have been made.

__________________________________________
Date                      Signature of Patient or Patient=s Guardian

__________________________________________
Date                      Signature of Witness
INFORMED CONSENT FOR EXTRACTION

I understand that there may be alternatives to the extraction of teeth and after the doctor’s explanation, I have chosen extraction. There are various normal complications that can occur despite all efforts to the contrary as a result of the extraction(s) which include but are not limited to:

- Allergic reaction to medications or anesthetics used
- Pain, swelling, infection, bruising, bleeding
- Stiffness of the nearby muscles
- Numbness
- Root tips may fracture and be left in place or could be displaced into the sinuses and/or spaces nearby
- Dry sockets, aspiration and/or swallowing of foreign objects
- Damage to adjacent teeth and/or restorations

I further understand that this procedure can also be performed by a specialist and prefer that this treatment be rendered in this office by a general dentist.

The dental care and treatment to be performed has been explained to me and I understand what is to be done and that there is no warranty or guarantee as to any result and/or cure. I may ask the attending dentist for a more complete explanation.

This is my consent for the extraction, anesthetics, and x-rays to be taken.

I have read and understand the above and have had all my questions answered to my satisfaction and I agree to proceed with the recommended extractions(s).

____________________________  ______________________________
Date       Signature
INFORMED CONSENT AND PERMISSION FORM

Before you give your permission for the removal of teeth, removal of impacted teeth (those that are buried or beneath the gums), or other dental treatment, and for the administration of certain anesthetics, you should understand there are certain associated risks.

The common risks are (but not limited to):

1. Drug reactions and side effects
2. Damage to adjacent teeth or fillings
3. Post-operative infection
4. Post-operative bleeding that may require treatment
5. Possibility of a small fragment of root being left in the jaw when its removal would require extensive surgery
6. Delayed healing (dry socket) necessitating frequent post-operative care
7. Possible involvement of the sinus during removal of upper molars which may require additional treatment surgical repair at a later date.
8. Possible involvement of the nerve within the lower jaw during the removal of lower molars resulting in temporary (but possible permanent) tingling or numbness of the lower lip, chin or tongue on the operated side.
9. Bruising and/or vein inflammation at the site of administration of intravenous medications which may require further treatment
10. Other: ................................................................................................................................................................
    ...........................................................................................................................................................................

I was given the option of different anesthetic techniques, and I consent for the following anesthetics to be used:

_____ Local anesthesia
_____ Local anesthesia with oral pre-medication
_____ Local anesthesia with intravenous sedation
_____ General anesthesia/hospital operating room

I hereby acknowledge I have completely read the foregoing; have discussed any questions or concerns which I may have regarding my proposed surgery/dental treatment, and have been given satisfactory answers. I am aware the practice of dentistry is not an exact science, and no guarantees can be provided.

__________________________________________________________________ (please print)

Last     First     Initial

_________________  __________________________________________

Date     Signature of patient; patient=s guardian or authorized representative

_________________  ________________________________ __________

Date     Witness signature
1. WORK TO BE DONE: I understand that I am having the following work done: Fillings ( ), Bridges ( ), Crowns ( ), X-rays ( ), Extractions ( ), Impacted teeth removed ( ), Root Canals ( ), Dentures ( ), Other ________________. (Initials ________)  

2. DRUGS AND MEDICATION: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. (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. For example, root canal therapy following routine restorative procedures. I give my permission to my 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, 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 (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility. (Initials ________)  

5. CROWNS, BRIDGES, AND CAPS: 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 the final opportunity to make changes in my news crown bridge, or cap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation. (Initials ________)  

6. ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. (Initials ________)  

7. PERIODONTAL LOSS (TISSUE AND 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 procedure may have a future adverse effect on my periodontal condition. (Initials ________)  

8. FILLINGS: I understand that care must be exercising in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials ________)  

9. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of 30 days, there will be additional charges. (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 hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees. I agree to pay any attorney's fees, or court costs, that may be incurred to satisfy this obligation.

Signature of Patient _____________________________ Date: _____________________________
Signature of Dentist _____________________________ Date: _____________________________
INFORMED CONSENT

PATIENT: ___________________________________________ DATE: __________________

1. I, __________________________________________, authorize Dr. ______________________ and/or such assistants as
   may be selected by him/her to attempt to remedy the following condition(s) or symptom(s) which appear
   indicated by the diagnostic procedure(s) already performed: .................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................

2. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no
   guarantees have been made to me concerning the results of the surgery or dental procedures(s).

3. I further acknowledge that the only statements or representations upon which I have relied to consent to this
   surgery or dental procedure(s) are those contained in this form.

4. The condition(s) listed in paragraph 1 have been explained to me, and I understand the nature of the surgery,
   dental procedure(s) and anesthetic/sedation procedure(s) to be as follows: .................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................

5. I have been advised of the availability of, and risks inherent in the following alternate method(s) of
   treatment:
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................

6. I recognize the need for my dentist to exercise his/her professional judgment on my behalf and I therefore
   specifically authorize my dentist to select alternate methods of treatment based on my condition as disclosed
   during the procedure(s) authorized by my execution of this form, including conditions which were unknown
   at the time the surgery or dental procedure(s) were begun.

7. I understand that there are certain inherent risks and consequences that may be associated with any surgical,
   dental or anesthetic/sedative procedure(s). I understand that not every conceivable hazard can be listed. I
   realize the following possibilities exist, however infrequent or rare: allergic reactions to medications,
   anesthetics, etc.; drug interactions and side effects; excessive bleeding (during the procedure and/or after the
   procedure); postoperative bruising and discomfort; blood clots anywhere in the body; postoperative infection
   or bone inflammation; possible involvement of the sinus of the upper jaw during removal of upper back
   teeth, requiring possible surgery for repair at a future date; possible involvement of the nerve withing the
   lower jaw during removal of lower teeth, resulting in usually temporary but sometimes permanent numbness
   and/or tingling in the lower lip and/or tongue; fracture or dislocation of the jaw; bruising and/or vein
   inflammation at the site of injections; damage to adjacent teeth, restorations and/or gum tissue. THESE
   ARE NOT PROBABLE RESULTS, THEY ARE STATISTICAL POSSIBILITIES.

8. I am also aware that certain specific risks and consequences may be associated with the surgery, dental
   procedure(s) and anesthetic/sedative procedure(s) outlined in paragraph 4, including: ........................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................

9. Knowing these risks, I consent to the surgery, dental procedure(s) and anesthetic/sedative procedure(s)
   outlined in paragraph 4.

________________________________________________________________________
Signature          Date
CONSENT FOR GINGIVAL AUGMENTATION SURGERY

I hereby authorize Dr. ___________________________ (herein called Doctor) to perform gingival augmentation surgery on myself.

**Diagnosis:** After a careful oral examination and study of my dental condition, my periodontist has advised me that I have significant gum recession. With this condition, further recession may occur. In addition, for fillings at the gumline, it could be important to have sufficient width of attached gum to withstand the irritation caused by the fillings or their edges. Gum tissue may also be placed to improve appearance and to protect roots of teeth.

**Recommended Treatment:** In order to treat this condition, my Doctor has recommended that gingival augmentation procedures be performed in areas of my mouth with gum recession. A local anesthetic will be administered in addition to medications deemed appropriate by my Doctor. This surgical procedure involves the transplanting of a thin strip of gum from the root of my mouth or from the adjacent teeth. The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed as to partially cover the tooth root surface exposed by the recession. A periodontal bandage or dressing may be placed.

An alternative technique consists of the placement of a bone regenerative material (human bone obtained from a tissue bank) and a non-restorable membrane on the root surface. In that case, the membrane requires a small surgical procedure after about six weeks to remove the membrane.

**Expected Benefits:** The purpose of gingival augmentation is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Another purpose of this procedure may be to cover exposed root surfaces, to enhance the appearance of teeth and gum line, or to prevent or treat root sensitivity or root decay.

**Principal Risks and Complications:** Some patients do not respond successfully to gingival augmentation. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during healing. In such a case, the attempt to cover the root surface may not be completely successful. In some cases, it may result in more recession with increased spacing between the teeth. I understand that unforeseen changes may lead to a change in my dental treatment plan. This may include, but is not limited to: (1) the need for additional dental work, or (2) modification of the planned dental work.

I understand that complications may result from the surgery and/or any drugs used. These complications may include, but are not limited to, infection; bleeding; swelling; pain; temporary discoloration of my face; increase tooth looseness; tooth sensitivity to hot, cold, sweet or acidic foods; shrinkage of the gum upon healing, resulting in elongation of some teeth and greater spaced between some teeth. Allergic reactions and accidental swallowing or inhaling of foreign matter are also possible. The duration of complications can not be determined, and complications may be irreversible.
No method can accurately predict or evaluate have my gum and bone will heal. There may be a need for a second procedure if the initial results are not satisfactory. The success of gingival augmentation can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my Doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have now or have had at any time in the past.

**Alternatives to Suggested Treatment:** My periodontist has explained alternative treatments for my gum recession. These include no treatment; continued monitoring for progressive recession; and modification of technique for brushing my teeth. Principal risk with any of these alternatives includes continued recession with further exposure of the root and possible tooth loss.

**Necessary Follow-Up and Self-Care:** It is important for me to: (1) abide by the specific prescriptions and instructions given by my Doctor, and (2) see my Doctor and my regular dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. Adequate daily oral hygiene performed with a non-traumatic method of brushing my teeth is essential for the success of the procedure. Although my Doctor informs me when the next periodic visit is needed, I am responsible for contacting the Doctor’s office to make appropriate appointments.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. However, there is a risk of failure, relapse, additional treatment, or worsening of my present condition resulting in the loss of my teeth despite the best of care.

Publication of Records: I authorize that my dental records, slide, x-rays or any other information pertaining to my treatment to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public.

I have read this entire form and understand everything explained in it. I have had the opportunity to ask the doctor about any questions I may have about the treatment, the risks of surgery, the alternative treatment methods and the substantial risks of the alternative treatment methods. The doctor has answered all my questions. I authorize the Doctor and whomever they may chose as their assistants to perform the proposed periodontal surgery.

___________________________________________  _______________________
Signature        Date

___________________________________________  _______________________
Witness        Date
INFORMATIONAL PURPOSES ONLY

INTRAVENOUS SEDATION

I, ________________________________, consent to the use of intravenous sedation for my periodontal treatment and to the use of medications deemed appropriate by my doctor. I understand I will be conscious but deeply relaxed during the procedure.

I have been advised of the following:

1. I must arrange for someone to pick me up at the office at the conclusion of the appointment and drive me home.

2. I could experience drowsiness for up to 48 hours following the procedure. I should not drive a car or operate machinery for up to 24 hours.

3. In rare instances, an infection (phlebitis) can develop in the arm at the site of the I.V. This can be accompanied by redness, swelling and soreness of several weeks duration.

4. I understand that my pulse rate and heart rhythm (ECG) will be monitored during my procedure. Should the need arise during the procedure, medications may be utilized to reverse the effects of the sedation.

My questions have been answered to my satisfaction regarding the use of intravenous sedation for my treatment.

__________________________________________
Date                  Signature of Patient

__________________________________________
Date                  Signature of Witness
INFORMATIONAL PURPOSES ONLY

CONSENT FOR MAXILLARY SINUS ELEVATION SURGERY

I hereby authorize Dr. __________________________ (herein called Doctor) to perform maxillary sinus elevation surgery on myself.

**Diagnosis:** My Doctor has told me that I have an insufficient bone height in my upper jaw to place root shaped dental implants of adequate length.

**Recommended Treatment:** In order to be able to place root shaped implants of adequate length in my upper jaw, my Doctor has recommended that my treatment include maxillary sinus elevation surgery. A local anesthetic will be administered in addition to medications deemed appropriate by my Doctor. Oral antibiotics may be prescribed.

My gum tissue will be pulled back and an opening will be created in the wall on the side of my maxillary sinus. After access to the sinus is created, the lining of sinuses will be lifted. Underneath the lining, a bone graft will be placed. This graft may include my own bone, synthetic bone substitute, human bone obtained from tissue banks, or a combination of these. Prefabricated membranes may also be used, which, if non-restorable, require a small additional surgical procedure for membrane removal.

Dental implants may or may not be placed at the same time of the sinus lift surgery. Whether implants will be placed at the same time can not be determined with certainty before the procedure, and I understand that implant placement may have to be delayed for as long a time as my Doctor deems advisable.

I understand that unforeseen conditions may call for changes in the anticipated surgical plan. These may include, but are not limited to: (1) extraction of teeth, (2) the removal of parts of teeth, (3) inability to start or complete the sinus elevation procedure. I understand that I consent to any such changes as deemed indicated in the opinion of my Doctor. Any of these unforeseen changes may lead to a change in my dental treatment plan. This may include, but is not limited to: (1) the need for additional dental work, or (2) the modification of the planned dental work. Some complications could include the need for a referral to other dental or medical specialists.

**Expected Benefits:** The expected benefit is that sufficient bone will be available in my upper jaw to allow placement of root-shaped implants.

**Principal Risks and Complications:** I understand that complications may result from the surgery and/or any drugs used. These complications may include, but are not limited to infection, bleeding, swelling, pain, temporary discoloration of my face, increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. Rarely, nerve damage can occur and infections can spread to other parts of the body. Nose bleeds can occur and local infection can spread to the bone (osteomyelitis). Failure of the bone graft can lead to failure of implants placed in the area, or inability to place the implants at a later date. Chronic or acute sinusitis may occur as a result of this procedure. Existing sinusitis may be aggravated or recur more frequently. Complications may be irreversible.
There may be a need for a second procedure if the initial results are not satisfactory. The success of sinus elevation procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my Doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have now or have had at any time in the past.

**Alternatives to Suggested Treatment:** Alternatives to the sinus elevation procedure include: no treatment, resulting in an inability to place implants of sufficient length in the area, (2) grafting on top of the bony ridge in the area, (3) anchorage of implants in anatomic areas behind the maxillary sinus (pterygoid plate anchorage) (4) false teeth unrelated to implants, such as removable partial and complete dentures. Principal risks are: alternative (1): premature loss of short implants; alternative (2): limited potential to obtain more bone; alternative (3): inducement of life-threatening bleeding and severe nerve damage: alternative (4): continued bone loss and inability to comfortably function with false teeth.

**Necessary Follow-Up and Self-Care:** It is important for me to: (1) abide by the specific prescriptions and instructions given by my Doctor, and (2) see my Doctor and my regular dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. It is essential that I follow the recommendations regarding the nature and timing of following implant-related treatment. I also need to inform my Doctor as soon as possible of any complications or symptoms that may relate to the sinus elevation procedure or placement of the graft implants. These symptoms or complications include, but are not limited to nose bleeds, pain, unusual feeling of sinus pressure, fever, swelling, pus formation and reactions to the medications prescribed. Although my Doctor informs me when the next periodic visit is needed, I am responsible for contacting the Doctor=s office to make appropriate appointments.

**No Warranty or Guarantee:** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. The sinus elevation procedure, although not experimental, is a fairly new surgical treatment. Its long term success and potential risks and complications may not be fully known.

**Publication of Records:** I authorize that my dental records, slides, x-rays or any other information pertaining to my treatment to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public.

I have read this entire form and understand everything explained in it. I have had the opportunity to ask the doctor about any questions I may have about the treatment, the risks of surgery, the alternative treatment methods and the substantial risks of the alternative treatment methods. The doctor has answered all my questions. I authorize Dr. ____________________________ and whomever they may chose as their assistants to perform the proposed sinus elevation surgery.

Signature of Patient ___________________________________________ Date: ___________________

Signature of Witness ___________________________________________ Date: ___________________
NITROUS OXIDE INFORMED CONSENT

I hereby give permission for Dr. ______________________ and staff to perform nitrous oxide sedation.

I understand that the administration of medication and the performance of conscious sedation with nitrous oxide carries certain common hazards, risks, and potential unpleasant side effects which are infrequent, but non the less, may occur. They include but are not limited to the following:

1. Excessive Perspiration: Sweating may occur during the procedure and you may become somewhat flushed during administration of nitrous oxide.
2. Expectoration: Removal of secretions may be difficult but can be controlled by use of suction tip.
3. Behavioral Problems: Some patients will talk excessively. You may become difficult to treat because you are so talkative, or experience vivid dreams associated with physical movement of the body.
4. Shivering: Although not common, shivering can be quite uncomfortable. Shivering usually develops at the end of the sedative procedure when the nitrous oxide has been terminated.
5. Nausea and Vomiting: This is the most frequent of the side effects of nitrous oxide sedation but its frequency is still quite low. It is important to tell the doctor, hygienist, or assistant that you are experiencing some discomfort. The level of nitrous oxide can be adjusted to eliminate this side effect.
6. Driving a Motor Vehicle: You may not feel capable of driving after nitrous oxide. If this occurs, we will keep you until you feel better or have you call a friend or cab to insure your safety.

I have been advised of alternative treatment, the benefits and risks which include but are not limited to:

- Fear and anxiety of the dental experience and/or avoidance of future dental appointments. These fears and anxiety, if not diminished by the use of nitrous oxide sedation, may precipitate other medical problems including fainting, palpitation and other heart-related disorders.

The benefits one can expect from nitrous oxide sedation include:

- Help with anxiety and pain, gagging and medically compromised individual.

I hereby certify that I understand this authorization and the reasons for the above named sedative procedure and associated risks. I am aware that the practice of dentistry is not an exact science. I acknowledge that every effort will be made in my behalf for a positive outcome from sedation, but no guarantees have been made to the result of the procedure authorized above.

___________________________________________  ______ ________________
Signature        Date
Complete occlusal equilibration is a dental procedure which may be performed over several visits, in which the occlusal surfaces of the teeth are meticulously altered in shape to meet predetermined criteria of an ideal occlusion. These criteria include, but are not limited to: simultaneous even contact and maximum intercuspation of all posterior teeth in centric relation position, force vectors of occlusion parallel to the long axes of the teeth, and immediate disclusion of the of the posterior teeth by anterior teeth in all eccentric movements of the mandible. The ultimate aim of this procedure is to achieve maximum relaxation of the jaw muscles during closure without mitigative alteration of the occlusal surfaces of the teeth. The object is to produce sufficient harmony between the modified occlusal anatomy of the teeth and the masticatory muscles and temporomandibular joints so that no pathology is produced within the tissues of the stomatognathic system.
OCCLUSAL EQUILIBRATION

1. **PURPOSE**: Teeth and jaws do not occlude (come together) in an acceptable position for many reasons, which may include: fillings or bridges that have been placed over a period of years, orthodontics, developmental defects, oral surgery, trauma, malocclusion (poor bite), bruxism, and clenching.

   Occlusal equilibration is the mechanical adjustment of your teeth, dentures, bridges, fillings, or other oral appliances to a position that allows your lower jaw to function in a natural hinge in relation to your upper jaw without improper influence from teeth.

2. **OCCLUSAL EQUILIBRATION B IS IT HARMFUL?**: Your mouth is being equilibrated because some problem exists: pain, abnormal wear, breaking of restorations, or other situations. The problem is usually present because the teeth and/or restorations do not meet in harmony with your lower jaw at the proper position. The teeth and fillings have not worn in properly. Occlusal equilibration wears some areas mechanically and allows the teeth to meet harmoniously. It is not harmful and is beneficial.

3. **THE FUTURE**: A simple occlusal equilibration can be accomplished in a short time. Only slight future changes in your occlusion (bit) occur over a period of time because of small movements of the teeth in the jaw bones. More complex equilibrations may require several appointments, and the teeth may shift more between appointments. When your symptoms are gone and your occlusion is relatively stable, your equilibration will be finished. Placement of any new fillings in your mouth will change the way your teeth contact. The dentist accomplishing this treatment should be advised of your past occlusion problem.

4. **HOW YOUR TEETH FEEL**: After occlusal equilibration, your occlusion (bite) will feel different to you. This is to be expected. You will gradually accept this location as your new chewing position, and it will feel very good.

5. If you have questions or problems, please call us.
INFORMED CONSENT TO OCCLUSAL EQUILIBRATION

Selective reshaping of the chewing surfaces of teeth with the intention to reposition the mandible and stress relieve the muscle in the head and neck suspension apparatus

_____ Direct Equilibration
_____ Following Preconditioning Appliance Therapy

Patient: _____________________________ Dentist: _____________________________

I the undersigned have sought or have been referred to the above named Doctor for occlusal equilibration, which I understand is a means of altering the chewing surfaces of some or all of my teeth, so that when my teeth come together, the temporomandibular joints (jaw joints) are in good anatomical position. I fully understand the importance of the history which I have given to the Doctor, which, together with the Doctor’s examination indicated that the symptoms which I have reported to the doctor may be improved and may be eliminated.

I understand that the Doctor does not guarantee that by changing the chewing surfaces of my teeth that any result is guaranteed, and in fact, I have been informed by the Doctor that there are possible complications which, although not likely to occur, may occur, despite the exercise of the Doctor’s greatest skill and care. These include but are not limited to: loss of some tooth enamel; the possibility that tooth or teeth may prove unsound and require restoration, including the replacement of existing restorations; that a tooth or teeth may require rebuilding by removing even greater amounts of tooth structure and replacing it with a crown, which may be expensive; pain in the face and jaws; chewing difficulty; joint noise; and sensitive teeth.

I further understand that additional dental services may be required in the future such as additional equilibration and any and all additional recommended dental care and treatment as set forth in the treatment plan presented by the Doctor, if one has been discussed and agreed upon. I further understand that if extensive equilibration is required that there may be some change in the appearance of the teeth and mouth and some increased sensitivity to temperature extremes. The Doctor has explained to me that there are other approaches to therapy, such as: occlusal appliance therapy, orthodontics, reconstructive dentistry, and orthognathic surgery. I understand that if any of these approaches are used, additional diagnostic aids and expense would be necessary. Although all these options have been discussed and offered to me, I have rejected them in favor of direct equilibration. Finally, I have received literature explaining occlusal equilibration which has been read and understood.

I fully consent to receiving occlusal equilibration from the Doctor and to pay all reasonable and necessary charges therefore which have been previously and fully explained to me.

________________________________  _________________ _______________
Date       Signature

________________________________  ________________________________
Doctor’s Agent     Parent or Guardian (if applicable)
CONSENT TO OCCLUSAL EQUILIBRATION

I (we) have sought or been referred to Dr. ______________________ for occlusal equilibration, which I (we) understand is a means of altering the bite or contact surfaces of some or all of my teeth, so that when my teeth come together, the jaw hinge, or temporomandibular joints, are in good anatomical position. I (we) fully understand the importance of the history which I (we) have given to the Doctor, which, together with his examination, indicates that my symptoms which I (we) have reported to the Doctor may be improved and may be eliminated. I (we) understand that the Doctor does not guarantee that by changing bite surfaces, any result is guaranteed, and in fact, I (we) have been informed by the Doctor that there are possible complications which, although not likely to occur, may occur, despite the exercise of the Doctor’s greatest skill and care. These include: loss of some tooth enamel; the possibility that a tooth or teeth may prove unsound and require restoration, including the replacement of existing restorations; that a tooth or teeth may require rebuilding by removing even greater amounts of tooth structure and replacing it with a crown, which may be expensive. I (we) further understand that additional dental treatment may be required in the future terms of additional equilibration, and any and all additional recommended dental care and treatment as set forth by in the Doctor’s treatment plan, if one has been discussed and agreed upon. I (we) further understand that if extensive equilibration is required, that there may be some change in the appearance of the teeth and mouth, and some increased sensitivity to temperature extremes. The Doctor has explained to me (us) that there are other approaches to therapy, such as: splint therapy, orthodontics, and orthognathic surgery. I (we) understand that if any of these approaches were used, several hundred dollars of additional diagnostic aids would be necessary, namely: hinge axis location, pantographic surveys, equilibrated study casts and possibly transcranial radiographs and arthrography. Although all these options have been discussed and offered to me, I (we) have rejected them in favor of direct equilibration. Finally, I (we) have received literature explaining occlusal equilibration which has been read and understood.

I (we) fully consent to receiving occlusal equilibration from Dr. ______________________, and to pay all reasonable and necessary charges therefore which have been previously and fully explained to me (us).

________________________________  _________________ _______________
Date       Signature

________________________________
Parent or Guardian (if applicable)
CONSENT FOR OPERATION AND ANESTHESIA

1. Operation and Alternatives
   A. I hereby authorize Dr. ________________________ and whomever he/she designates as his/her assistants to perform the following procedures necessary to treat my condition: ............................................
      ................................................... ................................................... ...................................................
      ................................................... ................................................... ...................................................
   B. I understand the reason for the procedure is: ...................................................... .............................................
      ................................................... ................................................... ...................................................
   C. Alternatives include: .............................................................................. ...................................................
      ................................................... ................................................... ...................................................
   D. It has been explained to me that conditions may arise during this procedure whereby a different procedure or an additional procedure may need to be performed and I authorize my surgeon and his/her assistants to do what they feel is needed and necessary.
   E. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.
   F. I consent to the examination and disposal by my surgeon and/or pathologist of any tissue or body parts which may be removed.

2. Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reaction and pneumonia. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular operation include: ....................................................................... ................................................... .................
   ..................................................................................................... ................................................... .................................

3. Anesthesia: The administration of anesthesia also involves risks, most importantly is the risk of reaction to medications causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services, with the exception of: ................................................................................................. ....
   ..................................................................................................... ................................................... .................................

4. Photography: I consent to the photographing of operations to be performed, including appropriate portions of my body for medical, scientific or educational purposes, providing my identity is not revealed by name in the descriptive texts accompanying them. This may exclude photographs of the face that are recognizable as me.

5. Patient=s Consent: I have read and fully understand this consent form, and I understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED SURGERY OR TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED SURGERY OR TREATMENT, ASK NOW, BEFORE SIGNING THIS CONSENT FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM!

__________________________________________________________ ____________________________
Patient signature (or parent or guardian)     Date

__________________________________________________________ ____________________________
Witness     Date

__________________________________________________________ ____________________________
Physician     Date
CONSENT FOR ORAL SURGERY

RECOMMENDED TREATMENT
I give permission to Dr. __________________ to perform the following treatment as well as any additional procedures considered necessary on the basis of findings during the actual surgery. This permission is for myself (or my ward or minor child) named below. I fully understand this consent for surgery and the reasons why the recommended treatment is necessary. I have been given the opportunity to ask questions regarding the recommended treatment and have been given satisfactory answers. I understand that no guarantee regarding the treatment has been made or implied.

TREATMENT __________________________________________________________

TREATMENT ALTERNATIVES
I elected the treatment listed above even though the following alternatives and associated risks have been explained to me.

TREATMENT ALTERNATIVES ____________________________________________

ANESTHESIA/MEDICATIONS
I also authorize the recommended treatment to be performed with the following anesthetics and/or medications:

- Local anesthesia only
- Local anesthesia with nitrous oxide and oxygen

RISKS AND CONSEQUENCES
I understand that there are risks associated with the administration of medications and performance of the recommended surgery such as the items checked below:

- Drug reactions and side effects
- Post-operative bleeding and pain
- Necessary removal of bone during tooth extraction
- Post-operative infection or bone inflammation
- Possible damage to the sinus when upper back teeth are removed which may require surgical repair at a future date
- Possible nerve damage when lower wisdom teeth are removed which can result in either temporary or permanent tingling or numbness in the lower lip
- Fracture of the mandible
- Jaw joint (TMJ) pain, malfunction and/or difficulty in opening mouth due to muscle spasms, following removal of the lower teeth

I agree that I have read, had explained to me and understand this consent for surgical treatment. I have been given the opportunity to ask questions concerning the treatment, the risks of treatment and the alternatives to treatment. After fully considering this information, I hereby consent to surgical treatment set forth above.

Date ________________________ Patient or Patient=s Guardian

Date ________________________ Witness
CONSENT FOR ORAL SURGERY

Patient=s Name: ________________________________________  Age: _____________

I hereby give consent to Dr. ______________________________ to perform the oral surgery procedure(s) for myself or my dependent as follows: ............................................................................................................................
............................................................................................................................
............................................................................................................................
and such additional procedures as are considered necessary for my well being on the basis of findings during the course of said procedure(s). The nature and purpose of the procedure have been explained to me and no guarantee has been made or implied as to result or cure.

Alternative methods of treatment have been explained to me, such as: ............................................................................................................................
............................................................................................................................
but I desire the treatment described above.

I also consent to the administration of local anesthesia and the taking of any radiographs (x-rays) as indicated.

I understand that the administration of medications and the performance of surgery can carry certain common, inherent risks, or complications such as, but not limited to: bleeding; swelling; discomfort; nausea; infection; drug reaction; delayed healing; damage to other teeth or restorations; bone fractures; and possible involvement of the nerve that could result in a usually temporary, but possibly permanent, numbness or tingling in the lower lip.

I agree to abide by the doctor=s post-operative instructions and that my failure to properly care for my oral health may lead to further complications.

Signed: _________________________________________ Date: ___________________

Relationship (to minor): __________________________________________________________

Witness (to signature only): _______________________________________________________

I acknowledge the receipt of, and understand my post-operative instructions.

Patient=s initials: ___________________________________

Patient=s Name: ___________________________________ Age: ___________
CONSENT FOR ORAL SURGERY AND ANESTHESIA

I hereby consent to the oral surgery indicated on the exam form and/or any related therapeutic procedures that in the judgment of the doctors may be necessary for my well-being. The nature and purpose of the operation and the therapeutic alternatives have been explained to me. No guarantee has been made or implied as to the result or cure.

I also consent to the administration of general anaesthesia, or intravenous sedation, or local anesthetics and the taking of radiographs as indicated.

I have been informed of all probable complications of the oral surgery and the use of anesthetics and other drugs. These complications include swelling, discomfort, nausea, vomiting, infection, numbness of the lip, chin, tongue, or gum, bone fracture, drug reaction, inflammation of a vein, delayed healing, damage to teeth and restoration, bleeding and sinus involvement.

I also understand that I am not to operate a motor vehicle or hazardous device for a 24-hour period following surgery. Medication for pain, sleep or sedation may cause drowsiness; therefore, alcohol should be avoided when such medications are taken.

I acknowledge the receipt of and understand postoperative instructions and have been given an appointment to return.

Signed: ________________________________________________________

Relation (if minor): _______________________________________________

Date: __________________________________________________________

Patient Name: ________________________________________ Date: ___________________

Proposed Operation:  ................................................................................. ................................................... ...............................................

This is my consent to the oral and maxillofacial surgery. I agree to the use of: (check one)

________ local anesthesia   ________ intravenous sedation

________ inhalation sedation  ________ ambulatory general anesthesia

There are possible complications of the surgery, drugs, and anesthesia. The more common complications are pain, infection, swelling, bleeding, or discoloration. There can also be pain or inflammation from injection into a vein. There is a possibility of injury to or stiffness of the facial muscles or the jaw. There is also the possibility of injury to adjacent teeth, restorations, or other tissues, referred pain to the ear, neck or head, nausea, vomiting, allergic reactions, bone fractures, and delayed healing. Sinus complications may also occur which might include an opening into the sinus from the mouth with the removal of upper teeth. Temporary or permanent numbness of the lip or tongue may occur following removal of lower teeth associated with these nerves.

Medications have the potential to cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol and other drugs. I agree not to operate any motor vehicle or hazardous machinery for a 24-hour period following the use of intravenous sedation. In addition, I understand that pain medication may also cause drowsiness, lack of awareness, and problems of coordination.

I understand I will receive appropriate post-operative instructions and will be given an appointment date to return for observation. There is no warranty or guarantee as to any result and/or cure. I understand that I can ask any questions regarding the procedure including a detailed explanation of the complications.

____________________ (Signature of patient or person with authority to consent for patient)

____________________ (Witness)
INFORMED CONSENT TO PERFORM ORAL SURGERY

I have been given a diagnosis based on the information gained by clinical exam of ..............................................................
..................................................................................................... ................................................... ........................................ .

I have been advised that the consequences of not treating this condition include but are not limited to: infection, swelling, pain, periodontal disease, malocclusion, fracture of the jaw and/or loss of bone. Impacted wisdom teeth are subject to and responsible for infections, cysts and tumors, cavities, pressure damage and periodontal damage to normal teeth, gum, and bone. These complications may cause pain, destroy jawbone and teeth, and adversely affect overall health.

Alternative treatments include but are not limited to: .................................................................................................. ............
..................................................................................................... ................................................... .........................................
..................................................................................................... ................................................... .........................................

I, the undersigned, give permission and consent to perform the following procedure(s): .......................................................
..................................................................................................... ................................................... .........................................
..................................................................................................... ................................................... .........................................

and understand that certain risks and consequences exist which include but are not limited to:

1. Post-operatively I can expect some pain, swelling, discoloration of the face, and/or bleeding. Swelling may occur for several days after surgery. Recuperation may require several days at home.

2. Local anesthetic reactions may occur. Although rare, this could include numbness, swelling, pain, infection, abnormal reactions or allergy and may adversely affect health. If you desire intravenous sedation or general anesthetic, or for any other reason we will refer you to an oral surgeon.

3. Numbness may occur in the region of the surgery, gums, lip or tongue. This is usually a temporary condition, but cases may be permanent.

4. A dry socket (poor healing of the socket) may occur. A dry socket is painful and requires frequent treatment at the office.

5. Root tips sometimes break off in the bone and may be left to avoid extensive surgery. With upper teeth, the root tips sometimes expose or are pushed into the maxillary sinus.

6. Infection is uncommon but may occur. Antibiotics may be needed postoperatively.

7. Fracture of the bone may occur.

8. Damage to adjacent teeth or restorations may occur.

9. Temporomandibular joint dysfunction (the jaw joint may not function well) may occur.

10. Any complications will be treated here or you will be referred to the appropriate specialist if additional treatment is needed. Treatment may consist of physical therapy, antibiotics or other drugs, or additional surgery.

I am aware that the practice of dentistry is not an exact science, that the very nature of the treatment and my uniqueness as an individual require that no predictions can be made. I acknowledge that no guarantees have been made to me. I believe it is in my best interest to proceed with my chosen treatment, as opposed to any alternatives which may exist. I have had ample opportunity to ask any questions I might have and have had them answered to my satisfaction. I agree to abide by the doctor=s post-operative instructions and that my failure to properly care for my oral health may lead to further complications. I have had the opportunity to discuss with the doctor my overall health and medical history. I accept the risks of subsequent harms, if any, in hopes of obtaining the desired beneficial results of this treatment.

The risks involved with anesthesia and the treatment itself have been fully explained to me and I do give my free and voluntary informed consent to the same.

________________________________________  ________________________
Signature of patient or person authorized to consent for patient    Date
PEDIATRIC DENTISTRY INFORMED CONSENT for
PATIENT MANAGEMENT TECHNIQUES
and ACKNOWLEDGMENT of RECEIPT of INFORMATION

State Law requires health professionals to provide their prospective patients with information regarding the treatment or procedures they are contemplating. State Law also requires us to obtain your consent for any specific dental treatment, procedures or techniques which might be considered to be of concern to the patient or parent. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child’s dental treatment after considering the risks, benefits and alternatives.

Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it.

It is our intent that all professional care delivered in our dental operatories shall be of the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist’s hands or the sharp dental instruments.

Alt efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. **Tell-show-do:** The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with Instruments on a model or the child’s or dentist’s finger. Then the procedure Is performed In the child’s mouth as described. Praise is used to reinforce cooperative behavior.

2. **Positive reinforcement:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.

3. **Voice control:** The attention of a disruptive child Is gained by changing the tone or increasing the volume of the dentist’s voice. Content of the conversation is less important than the abrupt or sudden nature of the command.

4. **Mouth prop:** A rubber or plastic device is placed in the child’s mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.

5. **Hand-over-mouth-exercise:** The disruptive screaming child is told that a hand will be placed over the child’s mouth. When the hand is in place, the dentist speaks directly into the Child’s ear end tells the child that if the noise stops the hand will be removed. When the noise stops the hand is removed and the child is praised for cooperating. If the noise resumes the hand is again placed on
the mouth and the exercise repeated.

6. **Physical restraint by the dentist:** The dentist restrains the child from movement by holding down the child’s hands or upper body, stabilizing the child’s head between the dentist’s arm and body, or positioning the child firmly in the dental chair.

7. **Physical restraint by the assistant:** The assistant restrains the child from movement by holding the child’s hands, stabilizing the head, and/or controlling leg movements.

8. **Papoose Boards and Pedi-Wraps:** These are restraining devices for limiting the disruptive child’s movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in these devices and placed in a reclined dental chair.

9. **Sedation:** Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally, by injection or as a gas (nitrous oxide and oxygen). The child does not become unconscious. Your child will not be sedated without your being further informed and obtaining your specific consent for such procedure.

10. **General anesthesia:** The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given general anesthesia without your being further informed and obtaining your specific consent for such procedure.
The listed pediatric dentistry behavior management techniques have been explained to me. Alternative techniques for treatment, if any, have also been explained to me, as have the advantages and disadvantages of each.

I hereby authorize and direct Dr.(s) ________________________________ assisted by other dentists and/or dental auxiliaries of his/her choice, to utilize the behavior management techniques listed on the reverse side of this form to assist in the provision of the necessary dental treatment for my child or legal ward:__________________________

..................................................................................................... ................................................... ...................................................
..................................................................................................... ................................................... ...................................................
..................................................................................................... ................................................... ...................................................

I hereby acknowledge that I have read and understand this consent, and that all questions about the behavior management techniques described have been answered in a satisfactory manner, and I further understand that I have the right to be provided with answers to questions which may arise during the course of my child’s treatment.

I further understand that this consent shall remain in effect until terminated by me.

Date: ________________________  Time: _____________

Patient’s Name: ___________________________________________

Signature of Parent or Guardian: ___________________________________________________

Relationship to Patient: __________________________________________________________

Witness Signature: ____________________________________________________________

I certify that I explained the above procedures and techniques to the parent or legal guardian before requesting their signature.

Signature of Dentist: ___________________________________________________________
CONSENT TO PERFORM PERIODONTAL CLEANING

I _________________________________, the undersigned, have been informed that I have periodontal disease, and that this disease process has been explained to me and that I fully understand the following:

1. This disease has resulted in the loss the bone which normally supports the teeth.
2. To help prevent the further loss of bone around my teeth, I must prevent buildup of live bacteria called bacterial plaque on a daily basis and it is my responsibility to schedule the regular dental checkups and cleaning=s after treatment is complete.
3. The proposed treatment plan to arrest the effects of periodontal disease that has been explained to me and I understand that additional treatment may be needed later if further problems develop.
4. As a result of periodontal root planing and curettage:
   a. The gums will be more receded where cleaned, and portions of the roots will be exposed post-cleaning.
   b. The exposed roots will be more sensitive to hot, color and/or sweets. This problem usually corrects itself in about six months time. Occasionally, further treatment may be needed. On rare occasions, this condition persists no matter what is done.
   c. The exposed roots, being more porous, will stain more easily than the crowns of teeth.
   d. Food will collect more easily between the teeth after meals.
   e. The teeth may be more loose immediately after cleaning. This occasionally persists indefinitely on isolated teeth where more bone loss has taken place. Normally, the teeth will eventually be about as loose as they were pre-operatively.
   f. If significant bone loss has occurred around upper front teeth, speech may be slurred post-operatively. In more severe cases, an appliance may be needed to replace missing gum tissue around front teeth for esthetics and to correct this speech problem.
5. Failure to follow these recommended actions will most likely result in continued bone loss with probably periodontal abscesses and eventually, tooth loss.
6. After an appropriate healing period, the status of periodontal disease will be evaluated. At that time, referral to a periodontist for periodontal surgery may be indicated.
7. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me.

The risks involved in the administration of anesthetics, sedative agents and the surgery itself have been fully explained to me and I do give my free voluntary informed consent to the same.

Date ___________________________ Signature of Patient
INFORMED CONSENT STATEMENT  
PERIODONTAL DISEASE

This information is to ensure you that you are aware of the existing periodontal disease (gum disease) and infection that is present in your mouth. It is to acknowledge that you have been informed of the existence of this disease and given a copy of the periodontal pocket charting. The consequence of non-treatment will result in a progression of this infection, and if it continues will generally result in eventual bone loss, loosening of teeth and often loss of teeth. This also acknowledges the fact that on this date at least two options for treatment were offered:

1. A non-surgical approach to periodontal disease in which you are a co-therapist

2. Referred to a periodontal specialist for a surgical approach to therapy, or other as deemed appropriate

_______ I accept option 1, for which a fee of $__________ has been quoted and I accept responsibility for the same.

Date: __________ Signature of Patient: ________________________________

_______ I prefer to be referred to a specialist for treatment.

Date: __________ Signature of Patient: ________________________________

_______ I decline both options 1&2, and prefer to have only a basic cleaning of my teeth, knowing that cleaning by itself will not prevent advancement of my disease or correct the disease. I also understand the consequences being potential loss of bone and teeth due to non-treatment of the disease.

Date: __________ Signature of Patient: ________________________________

Date: __________ Signature of Witness: ________________________________
INFORMED CONSENT STATEMENT
FOR PERIODONTAL THERAPY

Please read the following information carefully. Risks associated with your periodontal therapy are explained below. Please take the time you need to ask all your questions before you sign.

Periodontal therapy can be required for a variety of reasons. These reasons include the persistence of periodontal pockets that make proper cleaning of the teeth and gums impossible, the presence of infection and the loss of bone support to the teeth. Periodontal therapy is performed to reduce or eliminate these pockets, remove unhealthy tissue and to thoroughly clean the root surfaces of the teeth. However, due to many factors such as advanced state of disease, lack of adequate home care, nutritional or hormonal factors, etc., your problem may persist or even worsen with time and teeth could be lost in the future.

It is important that you are aware that the success of your periodontal therapy is largely dependent on you. You must follow the instructions for home care very closely to get a good result. You should expect increased sensitivity of the tooth roots to cold, heat or sweets. This normally decreases over time, but the intensity and duration of discomfort vary greatly from person to person. Please be assured that we will use the utmost care in performing this procedure and have every reason to expect success.

I have read the above and have discussed with the Doctor the risks and treatment options of periodontal therapy. I understand that dentistry is not an exact science and no guarantee can be made to me. I hereby give my permission to proceed with the periodontal therapy.

Fee: _____________________

_________________________ ______________________________________________________
Date   Signature of Patient

Please read and sign the following if you wish to decline the recommended treatment.

I have been warned of the consequences of refusing the periodontal therapy. I fully realize that this recommended treatment is needed. However, at this time, I cannot arrange for the needed treatment and release the Doctor and his/her staff completely of any responsibility for the resulting long-term ill effects.

_________________________ ______________________________________________________
Date   Signature of Patient
POST-OPERATIVE ORAL SURGERY INSTRUCTIONS

Care of the mouth following a surgical procedure is essential in the healing process. There is a certain amount of swelling, discoloration, discomfort and bleeding which can be expected.

**BLEEDING:** Some bleeding and oozing is to be expected for several hours. Avoid spitting and use of a straw as they may provoke oozing. Keep firm pressure on the gauze pack for 30 minutes and then discard. If bleeding is more than slight, use sterile gauze or a moistened tea bag over the area and again apply firm pressure for 30 minutes.

**DISCOMFORT:** If prescription was given, use as directed. The prescription should be filled promptly and taken exactly as directed before the local anesthesia wears off. Do not take pain medication on an empty stomach as it may cause nausea. If prescription was not given, over-the-counter medications (aspirin, Tylenol or Advil) can be taken as directed.

**SWELLING:** Some degree of swelling is normal and can be minimized with the use of ice or cold packs applied to the face at the extraction site for 15-20 minutes and then removed for 15-20 minutes. This should only be done for the first 24 hours. Maximum swelling will occur about the second or third post-operative day and then slowly recede.

**DIET:** A soft or liquid diet is recommended for the first few days following surgery. Until local anesthesia (numbness) wears off, be careful chewing to prevent biting the numb area.

**CARE OF MOUTH:** Do not rinse your mouth for 24 hours after surgery. After 24 hours, begin gentle warm salt water rinses for one week and resume gentle brushing of remaining teeth. Avoid use of alcohol, smoking or carbonated drinks for 24-48 hours after surgery. This may interfere with clot formation and slow the healing process.

**NOTE:** Antibiotics may decrease the effectiveness of birth control medications. Additional methods of birth control should be used while on antibiotics.

If any problems arise or if you have any questions, do not hesitate to call our office anytime at ____________________________.
SPLINT TREATMENT

A splint, or mandibular orthopedic repositioner is a removable appliance worn over the teeth to passively reposition the lower jaw to its physiologically most stable position. This positioning is needed for those with temporal mandibular joint (TMJ) problems or those requiring extensive restorative dentistry, in order to plan and perform further treatment needs. For splint therapy to be successful, 24-hours a day wear is required with removal only to clean it and the teeth.

For those wearing a splint wearing TMJ conditions involving limited or compromised function and/or pain may be secondary to other processes. These include but are not limited to traumatic injury, disc displacement, degenerative joint disease, inflammation, infection, arthritis, developmental or congenital defect, malrelation of the arches of the teeth, or systemic disorders.

For those with TMJ problems, such as symptoms as headaches, stiff necks, ringing in the ears, popping and clicking noises in the joints, and clenching and grinding of the teeth, can be relieved. Due to the complexity of the joints, and in most cases the duration of the problem, there is no assurance that all symptoms will go away or improve. Therefore, splint therapy is not just treatment, but also a diagnostic tool for us to determine what is happening in the joints. Radiographs such as tomograms or arthrograms may be needed through the duration of splint therapy depending on the course of treatment. Also, cross referrals to other specialties such as orthodontia, oral surgery, physical therapy etc. may be needed depending on oral surgery, physical therapy etc. may be needed depending on symptom ology. The length of treatment with a splint can be as short as 1-2 months for a restorative patient to as long as 1-2 years for a TMJ patient. The average patient is 5-10 months in treatment.

Once splint therapy is completed and this stable mandibular position has been located, an extensive occlusal (bite) analysis must be performed in order to make the diagnosis of how we are going to make the teeth fit together in this new position and resulting in malocclusion. This fitting of the bite may involve which things as equilibration, (a very sophisticated bite adjustment), orthodontia, oral surgery, reconstructive dentistry or any combination thereof. The treatment needed will be based on what the occlusal analysis shows. At this time, and extensive consultation will occur to inform you of recommended post splint treatment needs. It is important the patient understand equilibration, orthodontia, surgery or reconstruction is a possibility for every splint patient. Also, it is impossible to predict what will be needed with any certainty until after the occlusal analysis. Therefore, any patient considering splint therapy should be prepared for any of these recommendations prior to starting treatment.

There are always some substantial risks and complications with any treatment. Some of these include but are not limited to:

1. Lack of improvement of worsening of pain & jaw dysfunction
2. Resultant malocclusion and/or limited jaw opening
3. Further degenerative changes in the TMJ
4. Decreased lower jaw motion.
5. Noises in the TMJ

The amount of the risks are dependent on the present condition of TMJ, the body’s host, response, and environmental influence.

Due to the complexity and duration of the problem with the joint, there can never be any assurance that the joint will always be healthy after treatment. Final occlusal treatment gives us the best opportunity to keep the joint healthy but again will not ensure it. There are many environmental factors (such as stress and bruxism, but not limited to those) that have an effect on the health of the joint. Any bone changes in the joint and position of the meniscus is always a concern in treatment. Whenever possible, final occlusion treatment will be done with the meniscus in position over the head of the lower jaw. If it is know that the meniscus is or could be out of position, we will inform you, but on
occasion it is possible that this may not be known. This can occur when the patient is comfortable and has no other signs or symptoms indicating it. Further diagnostic studies to determine this are invasive and may not be indicated. If the meniscus is out of position and the patient is comfortable, it will become the patients decision if final occlusal treatment should be proceeding with. If the meniscus is out of position, and the patient is not comfortable, further evaluation by other health professionals, including surgical evaluation, may be necessary.

We hope this narrative has provided you the information you need, but if you have ANY FURTHER QUESTIONS, PLEASE FEEL FREE TO ASK. Also, if you would like a list of patients undergoing or having undergone this treatment, we will be glad to provide it.

I hereby acknowledge that I have completely read the foregoing, HAVE DISCUSSED ANY QUESTIONS OR CONCERNS regarding my treatment and acknowledge I have received a copy of this form.

Signature _________________________________________   Date_______________________

Witness ___________________________________________   Date_______________________

Dentist _____________________________________________   Date_______________________
SURGICAL INFORMED CONSENT

I hereby give permission to Dr. _____________________ to treat me (or my dependent ______________) and authorize the following procedure or such additional procedures as are considered necessary on the basis of findings during the course of said procedure: ........................................................................................... ................................................... ................................................... ..........................................
................................................................................................................................................
The following reasons are why the above named surgery is considered appropriate: ............................................................... ................................................... ................................................... ..........................................
................................................................................................................................................
The following alternative treatment methods have been explained to me: ...............................................................................
................................................................................................................................................
................................................................................................................................................
I have also been advised as to the probable outcome if no treatment is provided for this condition.

I consent to the following anesthesia and/or medications to be given at the time of surgery:
   1. Local anesthesia
   2. Local anesthesia with nitrous oxide/oxygen
   3. Local anesthesia with nitrous oxide/oxygen and intravenous sedation

I understand there are certain common inherent risks possibly associated with this surgery and anesthesia including but not limited to:
   1. Drug reactions and side effects
   2. Post-operative bleeding, swelling, bruising, pain and discomfort
   3. Post-operative nausea, weakness and possibly loss of time from work or school
   4. Post-operative infection, delayed healing, bone inflammation
   5. Sinus involvement possibly requiring additional treatment or surgery
   6. Nerve injury within the lower jaw resulting in temporary but possibly permanent numbness and/or tingling of the lower lip, gums, or jaw
   7. Bone fracture
   8. Bruising or inflammation at the site of the intravenous injection

I understand the risks of driving, operating hazardous equipment, and drinking alcohol while recovering from anesthesia and while taking prescribed pain medication. I have been given the opportunity to ask questions regarding this treatment to clarify by understanding.

I am aware that the practice of oral surgery is not an exact science and I acknowledge that no guarantees have been made to me with regard to the procedures listed above.

....................................................................................................................................................................................
Date   (Signature of patient or person with authority to consent for patient)
....................................................................................................................................................................................
Date   (Dentist)
....................................................................................................................................................................................
Date   (Witness)
INFORMED CONSENT FORM

The doctor has explained to me the problem that exists with my teeth, mouth, and/or jaws. I understand that the nature and purpose of the surgical procedure(s) indicated to me by the doctor have been clearly explained to me together with attendant debility which may include but not limited to pain and swelling, bruising, altered diet, and limitation of jaw function. I accept the possibility that unforseen conditions may arise during my treatment that require modification, addition or alteration of the planned procedure(s). I hereby request and authorize the doctor to render such other procedures he/she deems advisable, necessary and therapeutic. I understand that dental surgery is not an exact science and that no guarantees have been made or implied.

I give my consent to the indicated procedure(s) realizing that risks and consequences may follow even when the procedure(s) is performed with the utmost care, judgement and skill. Those risks and consequences may include but are not limited to the following:

1. Numbness of the lower lip, chin and/or tongue resulting from injury to nerves close to the surgical area, usually temporary but on rare occasions may be permanent.

2. Delayed healing with or without infection, and/or premature clot loss which may require secondary treatment.

3. Excessive bleeding which may require secondary procedure(s) to control; damage to adjacent teeth or fillings; leaving selected pieces of teeth root in the jaw; opening into the maxillary sinus and/or jaw fracture, both of which may or may not require secondary procedure(s); bone chips following tooth removal which may require secondary care.

I agree to cooperate completely with the doctor while under his/her care realizing that any lack of same could contribute to less than optimum results. The doctor has made me fully aware of alternative treatment and/or the possible consequences of no treatment. I have had adequate opportunity to discuss my past medical and health history. I am fully aware of fee for services, the payment of which I accept as my responsibility and obligation.

By my signature, I certify that I have had adequate opportunity to read and understand the terms, words and inferences within the consent.

....................................................................................................................................................................................
Date   (Patient/Guardian/Parent)

....................................................................................................................................................................................
Date   (Witness)

I have explained the procedure(s), alternatives, and risks to the person whose signature is above.

....................................................................................................................................................................................
Date   (Dentist)
I hereby authorize Dr. _________________ and whomever he/she may designate as assistants to perform upon me the following operation and procedures:

....................................................................................................................................................................................
....................................................................................................................................................................................
....................................................................................................................................................................................

and if any unforeseen condition arises in the course of these designated operations or procedures calling, in his/her judgement, for procedures in addition to or different from those now contemplated, I further request and authorize them to do whatever they deem advisable.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In Endodontic surgery, the most common of these complications include leaving a small piece of root in the jaw if removal of the root would require extensive surgery, post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental fillings. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness of lip, chin and tongue), broken jaw, sinus exposure and swallowing or inhaling of instruments and fillings into lungs.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drugs or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), heart stoppage, and inhaling of stomach contents into lungs.

I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.

I further realize that in spite of the possible complications, my contemplated surgery is necessary and is desired by me. I am further aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

A FULL AND COMPLETE explanation of surgery and anesthesia is available to me upon my request from the doctor.

________________________  ____________________________
Date   (Patient/Guardian/Parent)

________________________  ____________________________
Date   (Witness)
SURGICAL INFORMED CONSENT

I hereby give permission to Dr. _________________________ to perform the following procedure or procedures for myself or my dependent (________________________________) and such additional procedures as are considered necessary on the basis of findings during the course of said procedure: ________________________________________________________.

The following alternative methods of treatment have been explained to me as being practical and possible, but I desire the treatment mentioned above: ...................................................................................................................................................................................

I hereby certify that I fully understand this authorization for surgical treatment and the reasons why the above-named surgery is considered necessary. I have been given the opportunity to ask questions and have been given satisfactory answers.

I consent for the procedure(s) to be done with the following anesthesia and/or medications:

_____ Local anesthesia
_____ Local anesthesia with intravenous sedation
_____ Local anesthesia with nitrous oxide and oxygen
_____ General anesthesia

I understand that the administration of the anesthesia is to be applied by or under the direction of

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LIABILITY WAIVER

On _________________________, 19__ in the course of a dental examination performed by Dr. ________________________________, I was informed of the need for necessary diagnostic x-rays. I have voluntarily elected not to have this diagnostic function performed. This is being done against the recommendation of the above named attending dentist. I do not hold the above named dentist liable for any failure to diagnose, or any misdiagnosis due to a lack of the recommended diagnostic x-rays. My reason for not permitting these x-rays to be taken is

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............................................................................................................................................................
I assume full responsibility for any conditions relating to my dental health that may have been diagnosed had the recommended x-rays been taken.

_______________________________________  _________________
Signature       Date
INFORMATIONAL PURPOSES ONLY

X-RAY CONSENT WITHHELD

This will serve to document that I have refused to allow Dr. ________________ to take radiographs (x-rays) of my teeth for the purpose of diagnosis. I have had explained to me that my care would benefit from having x-rays taken and I understand the risks to my health of not having the x-rays taken.

_______________________________________  _________________
Patient=s Signature      Date
INFORMATIONAL PURPOSES ONLY

RADIOGRAPH WAIVER

I, _____________________________________________ request that the following proposed radiograph(s): ........................................................................................................................................ not be taken, even though such examination has been recommended by my doctor, and in so doing, hereby release Dr. ____________________________________ from any responsibility for diagnosis which should have been made after such radiographic examination had been completed.

Patient: ______________________________________ Date: _____________

Witness: __________________________________________________________
PULPOTOMY (PERMANENT TEETH)

A PULPOTOMY is an interim treatment done with the intention of temporarily preserving a vital tooth without removing all of the pulpal or nerve tissue. During a PULPOTOMY tissue is generally removed from the pulp chamber but tissue contained in the root canals of a tooth remains. Complete removal of tissue from within the tooth is termed a PULPECTOMY.

I UNDERSTAND that a PULPOTOMY is performed as a temporary measure in all but the most unusual cases in the attempt to preserve the tooth for an undetermined period of time depending upon the circumstances for which the temporary preservation is required and that this treatment may include possible inherent risks such as but not limited to the following:

1. **Root canal treatment**: Even though it is anticipated that this treatment may extend the time in which a tooth will remain vital until further necessary procedures may be successfully performed at a more appropriate time, it may be necessary to perform complete root canal treatment (pulpectomy) at any time if conditions should so dictate. Care should be taken not to unduly delay completion of the root canal process. Referral to an endodontic specialist may be necessary as determined by the attending dentist.

2. **Numbness**: There is the possibility of injury to the nerves of the face or tissues of the oral cavity during the administration of anesthetics or during the treatment procedures which may cause a numbness of the lips, tongue, tissues of the mouth, and/or facial tissues. This numbness is usually temporary, but may be permanent.

3. **Fracture**: Inasmuch as the crown portion of the tooth may have been weakened due to the extensive nature of the procedure and/or that the tooth injury or disease which necessitated this procedure, the tooth may be more susceptible to fracture or breakage.

4. **Temporary crown**: Should the tooth structure which is remaining appear to be excessively fragile, it may be necessary to place a temporary crown on the tooth in order to preserve it.

5. **Extraction**: Should the tooth not heal, fracture extensively, or be unacceptable for having a complete root canal treatment performed, extraction of the tooth may be necessary.

6. **Pain**: In most cases, once the pulpectomy has been performed and the initial pain has subsided, the tooth is no longer painful. However, in some cases, severe pain or extreme sensitivity will persist. If so, it is the patient's responsibility to notify the dentist immediately.

7. **I acknowledge that it is my responsibility to seek attention should any undue problems occur after treatment. I shall diligently follow any preoperative and postoperative instructions given to me.**

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of having a pulpotomy procedure performed and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. and/or any associates to render that treatment necessary or advisable to my dental conditions, including the administration and/or prescribing of any and all anesthetics and/or medications.

Patient's name (please print)  Signature of patient, legal guardian or authorized representative  Date

Witness to signature  Date

(Rev. 7/07/03)
I UNDERSTAND that treatment of my dentition for which I desire cosmetic dental procedures to be performed may entail certain risks and possible unsuccessful results, with even the possibility of failure to achieve the results which may be desired or expected. I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following: (Even though care and diligence is exercised in this subject treatment, there are no guarantees of anticipated or desired results nor of the longevity of the treatment).

1. **Reduction or roughening of tooth structure:** In making preparation of teeth for the reception of cosmetic veneers, it may be necessary to slightly reduce or roughen the surface of the tooth to which the veneer(s) may be bonded. This preparation will be done as conservatively as possible. If the veneer covering breaks or comes off, the uncovered tooth may become more decay susceptible.

2. **Sensitivity of teeth:** Even though, in the majority of the cases (whitening, bleaching, bonding, and veneering teeth) there is usually no appreciable sensitivity, this type of treatment may cause teeth to become sensitive. Should sensitivity occur and persist for any length of time, please contact this office for an examination.

3. **Chipping, breaking or loosening of the veneer.** No matter how well done, this could occur. Many factors may contribute to this happening such as: mastication of excessively hard materials; changes in occlusal (biting) forces; traumatic blows to the mouth; breakdown of the bonding agents; and other such conditions over which the doctor has no control.

4. **Sensitive or allergic reactions of soft tissues to whitening, bleaching, or bonding agents:** Even though this is an unusual occurrence, the gums or soft tissues of the mouth which may be exposed to the various agents used in these procedures may exhibit an allergic response. Also, gum tissues may in some cases exhibit signs of inflammation. Should this occur, please contact this office to be examined.

5. **Esthetics/Appearance:** Every effort possible will be made to match and coordinate both the form and shade of veneers and/or bonding agents which will be placed in order to be cosmetically pleasing to the patient. However, there are some differences which may exist between the natural dentition and the materials which are artificial, making it impossible to have the shade and/or form perfectly match your natural dentition.

6. **Longevity:** It is in possible to place any specific time criteria on the length of time that veneers and bonding should last or for the lightened appearance of whitened or bleached teeth to maintain the lightened shades. These time periods may vary from a very short time to a very long time depending upon many conditions existing from patient to patient, and/or upon each patient's individual habits or circumstances, which may be either internal, external or both.

7. It is the patient’s responsibility to immediately inform the doctor and seek attention from him/her should any undue or unexpected problems occur or if the patient is dissatisfied. Also, all instructions must be diligently followed, including scheduling and attending all appointments.
INFORMED CONSENT TO TREATMENT: I have been given the opportunity to ask any and all questions regarding the nature and purpose of cosmetic dental treatment and have received all answers to my satisfaction. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for these services have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. ___________________________ and/or his/her associates to render any treatment deemed necessary, desirable, and/or advisable to me, including the administration and/or prescribing of any anesthetics and/or medications.

Patient's Name (please print)                                          Signature of patient, legal guardian, or authorized representative
                                                                                              Date

Tooth No.(s)  _______________________

Witness to signature                                          Date

(Rev. 1/1/96)
INFORMATIONAL PURPOSES ONLY

COMPOSITE FILLINGS

I UNDERSTAND that the treatment of my dentition involving the placement of composite resin fillings which may be more aesthetic in appearance than some of the conventional materials which have been traditionally used, such as silver amalgam or gold, may entail certain risks. There is also the possibility of failure to achieve the results which may be desired or expected. I agree to assume those risks which may occur even though care and diligence will be exercised by my treating dentist in rendering this treatment. These risks include possible unsuccessful results and/or failure which are associated with, but not limited to the following:

1. **Sensitivity of Teeth:** Often after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. The sensitivity may be mild to severe. The sensitivity may last only for a short period of time or may last for much longer periods of time. If such sensitivity is persistent or lasts for much extended periods of time, I agree to notify the dentist inasmuch as this may be a sign of more serious problems.

2. **Risk of Fracture:** Inherent in the placement or replacement of any restoration is the possibility of the creation of small fracture lines in tooth structure. Sometimes these fractures may not be apparent at the time of removal of tooth structure and/or the previous filling and placement or replacement, but may manifest at a later time.

3. **Necessity for Root Canal Therapy:** When fillings are placed or replaced, the preparation of the teeth for fillings often necessitates the removal of tooth structure adequate to insure that the diseased or otherwise compromised tooth structure provides sound tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying pulp tissue. Should the pulp not heal, which often times is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.

4. **Injury to the Nerves:** There is a possibility of injury to the nerves of the lips, jaws, teeth, tongue, or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness which may occur is usually temporary, but in rare instances could be permanent.

5. **Aesthetics or Appearance:** Effort will be made to closely approximate the natural tooth color. However, due to the fact that there are many factors which affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, over a period of time, the composite fillings, because of mouth fluids, different foods eaten, smoking, etc. may cause the shade to change. The dentist has no control over these factors.

6. **Breakage, dislodgment or bond failure:** Due to extreme masticatory pressures or other traumatic forces, it is possible for composite resin fillings or aesthetic restorations bonded with composite resins to be dislodged or fractured. The resin-enamel bond may fail, resulting in leakage and recurrent decay. The dentist has no control over these factors.

7. **New Technology and Health Issues:** Composite resin technology continues to advance but some materials yield disappointing results over time and some fillings may have to be replaced by better, improved materials. Some patients believe that having metal fillings replaced with composite fillings will improve their general health. This notion has not been proven scientifically and there are no promises or guarantees that the removal of silver fillings and the subsequent replacement with composite fillings will improve, alleviate, or prevent any current or future health condition.

8. I understand that it is my responsibility to notify this office should any undue or unexpected problems occur or if I experience any problems relating to the treatment rendered or the services performed.

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of composite fillings and have received answers to may satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired and/or any results from the treatment to be rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize Dr. ______________________________and/or all associates involved in rendering any services he/she deems necessary or advisable to treatment of my dental conditions, including the administration and/or prescribing of any anesthetic agents and/or medications.

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<th>Signature of patient, legal guardian</th>
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(Rev. 4/00)
INFORMATIONAL PURPOSES ONLY

SEALANTS

I UNDERSTAND that the treatment of teeth through the use of sealants is a preventive measure intended to facilitate the inhibition of dental caries (tooth decay) in the pits and fissures of the chewing surfaces of the teeth. Sealants are placed with the intent to prevent or delay conventional restorative measures used in restoring teeth with fillings or crowns after the onset of dental caries. I agree to assume any risks if any, which may be associated with the placement of sealants even though care and diligence will be exercised by Dr. ______________________ in rendering this treatment. Those risks include possible unsuccessful results and/or failure which are associated with, but not limited to the following:

1. **Preparation:** The teeth are prepared through use of an enamel etching technique. This etching is accomplished in one of two ways:
   a. Through using a special acid solution which merely etches the surface enamel in the area in which the sealant is to be placed to aid in its retention. The etching solution is somewhat caustic and if the patient makes any quick movements or interferes with the application of the etching agent there is a remote possibility of a small amount of the solution finding its way onto small areas of the soft tissues of the mouth which could cause some slight tissue burns. This seldom occurs, but there is a remote possibility. If the etching solution contacts the root surface the tooth may develop transient sensitivity.
   b. Through using a technique called air abrasion. Air abrasion also slightly etches the surface of the enamel in the area in which the sealant is to be placed to aid in the retention of the sealant. Air abrasion involves the generation of a powdery dust which is sometimes accidently inhaled and could cause some discomfort.

2. **Loosening and/or dislodging:** There is the possibility of the sealant loosening or becoming dislodged over a period of time. This time is indeterminable because of many variables including, but not limited to the following:
   a. The forces of mastication (chewing). These forces differ from patient to patient. The forces may be much greater in one patient than in another. Also, the way the teeth occlude (come together in chewing) may have an effect on the life of the sealants.
   b. The types of food or other substances that are put in the mouth and chewed. Very sticky foods such as some types of gum; sticky candies such as caramels; some licorices; very hard substances, etc; may cause loosening or dislodgment.
   c. Inadequate oral hygiene such as infrequent or improper brushing of the teeth also may allow leakage around and under the sealant causing it to loosen and allow decay to develop.

3. **Entire tooth is not protected with sealants:** Sealants are applied primarily to the pits and fissures that are in the chewing surfaces of the teeth. These pits and fissures are extremely susceptible to decay and can be protected through the application of sealants which flow into and seal those areas. However, sealants do not protect the areas between the teeth, so thorough brushing and the use of dental floss in these areas is necessary. Otherwise decay could develop in those areas uncovered by the sealants.

4. **I understand that it is my responsibility to notify this office should any undue or unexpected problems occur or if any problems relating to the treatment rendered are experienced. Routine examinations by the dentist are recommended to allow ongoing assessment of the sealants placed.**

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of sealants and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of achieving the desired results from the treatment rendered. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize Dr. ______________________ and/or all associates involved in rendering the services or treatment necessary to the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications.

Patient's name (please print) ____________________________ Signature of legal representative ____________________________ Date ____________________________

Witness to Signature ____________________________

(Rev. 10/00)
I UNDERSTAND THAT ROOT CANAL RETREATMENT includes possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of successful results have been made.

8. A tooth which has had root canal treatment previously may possibly become excessively tender or painful at some time following the initial root canal treatment for various reasons. Should this occur the tooth may require additional procedures, including retreatment, apical surgery, or extraction.

9. Should anesthesia be necessary there is a possibility of numbness occurring in the tongue, lips, teeth, jaws and/or facial tissues resulting from either the anesthetic administration or treatment procedures. Numbness is usually temporary but may be permanent.

10. Extensive complicated treatment may be necessary. When retreatment is necessary, the removal of the previous root canal filling material may involve difficulties such as pulp chamber or root perforation, root fracture, or other complications. This may possibly necessitate referral to a specialist or may even require extraction of the tooth.

11. Instrument separation may occur. Because of the small diameter and fragility of root canal instruments, there is a possibility of an instrument separating. Many times the separated part of the instrument can be removed or even retained without causing problems. No matter how carefully instruments are manipulated the possibility of separation exists.

12. A previously root canal treated tooth may subsequently become infected. Should this occur, it may be difficult to control the infection with retreatment only of the root canal and/or administration of antibiotics. The tooth may require a procedure called an apicoectomy that entails surgical removal of the end of the root and placement of filling material. In most instances, this treatment will take care of the problem. However, at times this procedure may not produce the desired result and preservation of the tooth.

13. A retreated tooth may become brittle. Because of the loss of vital tissue in the pulp chamber and root canal, a tooth may become excessively brittle and break (fracture). At times, this could occur subsequent to retreatment. In such cases, the tooth may be preserved with a crown buildup and a crown to restore the tooth unless the fracture is too severe or too extensive. Should the fracture be too extensive for a crown buildup or extend below the level of supporting bone, the tooth may need extraction.

14. Should extraction be required, replacement could be made with some type of prosthesis such as a fixed bridge, a removable bridge, or an implant.

15. Alternatives to root canal retreatment. Should it be determined to not retreat a tooth previously treated with a root canal procedure, alternatives such as extraction followed by fixed or removable bridgework, or implants may be considered.

16. Medications. Should infection and/or pain be present, it may be necessary to prescribe medication. Drugs prescribed must be taken strictly according to instructions. Patients on oral contraception must be aware that antibiotics may render these contraceptives ineffective. Other methods of contraception should be utilized during the treatment period if antibiotics are used.

17. TREATMENT MUST BE COMPLETED. It is absolutely necessary to complete the root canal retreatment procedure once it is begun, otherwise serious problems may develop. It is the patient’s responsibility to schedule and keep the necessary appointments and also to notify this office should unanticipated problems occur concerning the treatment. Also, the patient must diligently follow all preoperative and postoperative instructions and keep all scheduled appointments.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of root canal retreatment and have received answers to my satisfaction. I have been given the option of seeking this treatment from a specialist. I do voluntarily assume any and all possible risks including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. ________ and/or his/her associates or agents to render any treatment necessary and/or advisable to my dental condition(s), including prescribing and administering any and all anesthetics and/or medications.

Patient's Name (please print) Signature of patient, legal guardian, or authorized representative Date

Tooth No.(s) Witness signature Date
I UNDERSTAND that treatment of dental conditions requiring CROWNS and/or FIXED BRIDGEWORK includes certain risks and possible unsuccessful results, with even the possibility of failure. I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following: (Even though care and diligence is exercised in the treatment of conditions requiring crowns and bridgework and fabrication of same, there are no promises or guarantees of anticipated results or the longevity of the treatment).

14. **Reduction of tooth structure:** In order to replace decayed or otherwise traumatized teeth it is necessary to modify the existing tooth or teeth so that crowns (caps) and/or bridges may be placed upon them. Tooth preparation will be done as conservatively as practical. In preparation of teeth, anesthetics are usually needed. At times there may be swelling, jaw muscle tenderness or even a resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues which is usually temporary, or, rarely, permanent.

2. **Sensitivity of teeth:** Often, after the preparation of teeth for the reception of either crowns or bridges, the teeth may exhibit sensitivity. It may be mild to severe. This sensitivity may last only for a short period of time or may last for much longer periods. If it is persistent, notify us inasmuch as this sensitivity may be from some other source.

3. **Crowned or bridge abutment teeth may require root canal treatment:** Teeth after being crowned may develop a condition known as pulpitis or pulpal degeneration. The tooth or teeth may have been traumatized from an accident, deep decay, extensive preparation, or other causes. It is often necessary to do root canal treatments in these teeth. If teeth remain too sensitive for long periods of time following crowning, root canal treatment may be necessary. Infrequently, the tooth (teeth) may abscess or otherwise not heal which may require root canal treatment, root surgery, or possibly extraction.

4. **Breakage:** Crowns and bridges may possibly chip or break. Many factors could contribute to this situation such as chewing excessively hard materials, changes in biting forces, traumatic blows to the mouth, etc. Unobservable cracks may develop in crowns from these causes, but the crowns/bridges may not actually break until chewing soft foods or possibly for no apparent reason. Breakage or chipping seldom occurs due to defective materials or construction unless it occurs soon after placement.

5. **Uncomfortable or strange feeling:** This may occur because of the differences between natural teeth and the artificial replacements. Most patients usually become accustomed to this feeling in time. In limited situations, muscle soreness or tenderness of the jaw joints (TMJ) may persist for indeterminable periods of time following placement of the prosthesis.

6. **Esthetics or appearance:** Patients will be given the opportunity to observe the appearance of crowns or bridges in place prior to final cementation. When satisfactory, this fact is acknowledged by an entry into the patient’s chart initialed by patient.

7. **Longevity of crowns and bridges:** There are many variables that determine how long crowns and bridges can be expected to last. Among these are some of the factors mentioned in preceding paragraphs. Additionally, general health, good oral hygiene, regular dental checkups, diet, etc., can affect longevity. Because of this, no guarantees can be made or assumed to be made.

8. **It is a patient’s responsibility to seek attention from the dentist should any undue or unexpected problems occur.** The patient must diligently follow any and all instructions, including the scheduling and attending all appointments. Failure to keep the cementation appointment can result in ultimate failure of the crown/bridge to fit properly and an additional fee may be assessed.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of crown and/or bridge treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks including those as listed above and including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. _________________________________ and/or his /her associates to render any treatment necessary and/or advisable to my dental conditions including the prescribing and administering any medications and/or anesthetics deemed necessary to my treatment.

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(Rev. 12/9/96)
I UNDERSTAND that REMOVABLE PROSTHETIC APPLIANCES (PARTIAL DENTURES and FULL ARTIFICIAL DENTURES) include risks and possible failures associated with such dental treatment. I agree to assume those risks and possible failures associated with but not limited to the following: (Even though the utmost care and diligence is exercised in preparation for and fabrication of prosthetic appliances, there is the possibility of failure with patients not adapting to them)

1. **Failure of full dentures:** There are many variables which may contribute to this possibility such as: (1) gum tissues which cannot bear the pressures placed upon them resulting in excessive tenderness and sore spots; (2) jaw ridges which may not provide adequate support and/or retention; (3) musculature in the tongue, floor of the mouth, cheeks, etc., which may not adapt to and be able to accommodate the artificial appliances; (4) excessive gagging reflexes; (5) excessive saliva or excessive dryness of mouth; (6) general psychological and/or physical problems interfering with success.

2. **Failure of partial dentures:** Many variables may contribute to unsuccessful utilizing of partial dentures (removable bridges). The variables may include those problems related to failure of full dentures, in addition to: (1) natural teeth to which partial dentures are anchored (called abutment teeth) may become tender, sore, and/or mobile; (2) abutment teeth may decay or erode around the clasps or attachments; (3) tissues supporting the abutment teeth may fail.

3. **Breakage:** Due to the types of materials which are necessary in the construction of these appliances, breakage may occur even though the materials used were not defective. Factors which may contribute to breakage are: (1) chewing on foods or objects which are excessively hard; (2) gum tissue shrinkage which causes excessive pressures to be exerted unevenly on the dentures; (3) cracks which may be unnoticeable and which occurred previously from causes such as those mentioned in (1) and (2); or the dentures having been dropped or damaged previously. The above may also cause extensive denture tooth wear or chipping.

4. **Loose dentures:** Full dentures normally become looser when there are changes in the supporting gum tissues. Dentures themselves do not change unless subjected to extreme heat or dryness. When dentures become loose, relining the dentures may be necessary. Normally, it is necessary to charge for relining dentures. Partial dentures become loose for the listed reasons in addition to clasps or other attachments loosening. Sometimes dentures feel loose for other reasons (See paragraph 1.).

5. **Allergies to denture materials:** Infrequently, the oral tissues may exhibit allergic symptoms to the materials used in construction of either partial dentures or full dentures over which we have no control.

6. **Failure of supporting teeth and/or soft tissues.** Natural teeth supporting partials may fail due to decay; excessive trauma; gum tissue or bony tissue problems. This may necessitate extraction. The supporting soft tissues may fail due to many problems including poor dental or general health.

7. **It is the patient’s responsibility to seek attention when problems occur and do not lessen in a reasonable amount of time; also, to be examined regularly to evaluate the dentures, condition of the gums, and the patient’s oral health.**

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of artificial dentures and have received answers to my satisfaction. I do voluntarily assume any and all possible problems and risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results relating to my ability to utilize artificial dentures successfully nor to their longevity. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I freely give my consent to allow and authorize Dr.________ to render the dental treatment necessary or advisable to my dental condition(s), including administering and prescribing all anesthetics and/or medications.

Patient's name (please print)   Signature of patient, legal guardian or authorized representative   Date

Witness to signature   Date
I UNDERSTAND that PERIODONTAL PROCEDURES (treatment involving the gum tissues and other tissues supporting the teeth) include risks and possible unsuccessful results from such treatment. Even though the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions, there are no promises or guarantees as to anticipated results. I agree to assume those risks and possible unsuccessful results associated with, but not limited to the followings:

1. **Response to treatment:** Because of many variables within each patient’s physiological make-up, it is impossible to precisely determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by both the treating dentist and the patient. Should the desired results not be achieved, extractions may be required.

2. **Postoperative patient responsibility for care:** With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment as instructed by the treating dentist. Without the necessary follow-up care by the patient, the probability of unsatisfactory results is greatly increased.

3. **Pain and soreness:** Periodontal surgery is often followed by substantial pain and soreness in the gums and bony tissues. This must be expected and instructions will be given as to the methods of controlling the problems of pain and soreness.

4. **Bleeding, bruising, and swelling:** Following periodontal surgery, there are occasions when relatively profuse bleeding may occur. Instructions as to how this may be controlled will be given to you. Some bruising and/or swelling of the intraoral and facial tissues may occur. If extreme, it is your responsibility to contact this office.

5. **Infection:** On occasion, postoperative infection(s) may occur. This may range from mild to severe in nature. Should you have any concerns relating to this potential problem, this office should be contacted as soon as possible.

6. **Reaction to medications or anesthetics:** Allergic reactions may exhibit themselves which may be mild to very severe in nature relative to medications, materials, and/or anesthetics. It is the responsibility of the patient to fully inform the treating dentist of any past allergic reactions.

7. **Injury to the nerves:** Surgical procedures or anesthetic administration may possibly result in injury to the nerves of the lips, jaws, teeth, tongue, other oral or facial tissues. Numbness could occur which usually is temporary, but rarely, may be permanent.

8. It is the patient’s responsibility to seek attention should any undue circumstances occur postoperatively and the patient shall diligently follow any preoperative and postoperative instructions received from the dentist and staff, including the scheduling and attending of each and every appointment.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if
any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr.____________________________ and/or his/her associates to render any treatment necessary or advisable to my dental condition, including administering and prescribing any and all anesthetics and/or medications.

Patient’s name (please print)  Signature of patient, legal guardian or authorized representative  Date

Witness to signature  Date

(Rev. 10/29/97)
PERIODONTAL PROCEDURES
SCALING AND ROOT PLANING

I UNDERSTAND that PERIODONTAL PROCEDURES (treatment involving the gum tissues and other tissues supporting the teeth) include risks and possible unsuccessful results from such treatment. Even though the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions through scaling and root planing and related procedures, there are no promises or guarantees as to anticipated results. I agree to assume those risks and possible unsuccessful results associated with, but not limited to, the following:

1. **Response to treatment:** Because of many variables within each patient’s physiological make-up, it is impossible to precisely determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by both Dr.____________________________ and the patient. Should the desired results not be attained, extractions may be required.

2. **Postoperative patient responsibility for care:** With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment, as instructed by the treating dentist. Without the necessary follow-up care by the patient, the probability of unsatisfactory results is greatly increased.

3. **Pain, soreness and sensitivity:** There may be post-operative discomfort which may be transitory or permanent, related to hot and cold stimuli, contact with teeth, and sweet and sour foods. The gums will also be sore immediately following treatment.

4. **Bleeding during or after treatment:** Laceration or tearing of the gums may occur which might require suturing. The gums may bleed as well during or after treatment.

5. **Recession of the gums after treatment:** After healing occurs, there may be gum recession which exposes the margin or edge of crowns or fillings, increases sensitivity of teeth, creates esthetic or cosmetic changes in front teeth which results in longer teeth and wider interproximal spaces visible as a black triangle. These wider interproximal spaces are more likely to trap food.

6. **Broken curettes, scalers or other instruments, and post-treatment infection:** It may be necessary to retrieve broken instruments surgically. Post treatment infection may also result from calculus being lodged in the tissue which may also require surgical intervention.

7. **Increased mobility (looseness) of the teeth during the healing period.**

8. **Noise and water spray:** Ultrasonic instrumentation is noisy and the water used may cause cold sensitivity during treatment on unanesthetized teeth not in the treatment field.

9. **Post-treatment complications:** Cracking or stretching of the lips/corners of the mouth during treatment is possible. There is the possibility that additional surgical treatment may be necessary after root planing.

10. **Sequela of local drug delivery:** If tetracycline fiber is used, there may be premature loss of the fibers necessitating a return visit to the dental office for replacement. There may be soreness or pain in the treated areas. The patient will be aware of the adhesive sealer, which often has granular surface. The sealer has an opaque or milky appearance and may be visible. There will be a need for a post-op
visit to remove the fibers seven to ten days after placement. There may be an adverse reaction to the antibiotic in the fiber whether a re-existing, known allergy exists or not.

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr._________________________ and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

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Date

(Rev. 10/29/97)
TEMPOROMANDIBULAR JOINT THERAPY (TMJ)

I UNDERSTAND that treatment of dental conditions pertaining to the TEMPOROMANDIBULAR JOINT includes certain risks and potential unsuccessful results. There exists the possibility that the TMJ problem may become worse through treatment. The treatment of TMJ problems is perhaps the most difficult procedure in dentistry in which to predict possible outcome. Even though great care and diligence will be exercised in this treatment, it is impossible to make any promises or guarantees for desired results nor can they be expected.

1. Depending upon the severity of the condition, treatment rendered may vary greatly. Discretion as to the method of treatment must be given to the treating dentist. There is no single right or wrong method of treatment. Engaging the help of a specialist or specialists may become necessary.

2. TMJ dysfunction is exhibited through many symptoms such as: pain and tightness in the jaw, head and neck; ringing and/or aching in the ears; headaches; clicking; restricted jaw movement; etc. Problems result from: dysfunction of jaw muscles and joints; traumatic injuries such as a blow to the jaw; teeth missing or misaligned; clenching or grinding of teeth; emotional stress; etc. Treatment may be simple such as leveling the bite through spot grinding of the teeth. This treatment could cause tooth sensitivity to develop which then may require additional dental procedures to be performed.

3. Comprehensive diagnostic evaluation, which may include x-rays, encephalographs, tomographs, study models, periodontal probing, and clinical charting, is essential to aid in the mode of treatment which is to be followed.

4. Splints/bite planes may be necessary in order to attempt to accomplish a desired result. These are usually fabricated from plastic materials and are worn by the patient for various periods of time as prescribed by the treating dentist. The purpose of this type of appliance is to attempt to position the patient’s jaws into a comfortable position. If and when such a position is able to be determined, a mode of treatment may then be pursued. This may include crowns, bridges, inlays, onlays, or other prostheses. It may be necessary to recommend orthodontic and/or surgical treatment. It is important to follow all instructions related to splint therapy and to be examined regularly. Unsupervised wearing of a splint may cause shifting of the teeth.

5. Discomfort and/or pain may be experienced in various degrees as treatment progresses in the attempt to achieve a successful and satisfactory result. Pain or discomfort may range from oral muscle soreness to a numbness of the lips, jaws, tongue, teeth, and/or facial tissues, which numbness is usually temporary, but, rarely, may be permanent.

6. Engaging the assistance of a specialist may be necessary in diagnosis and/or treatment. In order to treat patients with TMJ problems as thoroughly as possible, it may be necessary to engage orthodontists, prosthodontists, periodontists, oral surgeons, endodontists, dentists limiting their practice to TMJ therapy, psychiatrists, psychologists, etc., in the attempt to achieve desired results. This may not become apparent until some time later in the course of treatment. In most cases involving other professional help, this will necessitate additional expense during the course of treatment.

7. It is the patient’s responsibility to immediately seek attention should any undue or unexpected problems occur and to immediately notify this office if treatment cannot be continued in a timely manner or if any appointment cannot be attended. Absolute patient cooperation is necessary and mandatory during treatment.
INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of Temporomandibular Joint (TMJ) treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr.______________________________ and/or his/her associates to render any treatment necessary and/or advisable to my dental condition(s) including prescribing and administering any or all anesthetics and/or medications.

Patient’s name (please print)  Signature of patient, legal guardian  Date  
or authorized representative

Witness to signature  Date

(Rev. 1/1/96)
ORTHODONTIC TREATMENT

I UNDERSTAND that treatment of dental conditions pertaining to ORTHODONTIC TREATMENT (straightening or repositioning of teeth) includes certain risks and potential unsuccessful results. Even though great care and diligence will be used in treatment, no promises or guarantees for desired results can be made nor expected.

1. Complete cooperation of the patient is essential. Once treatment is begun, each appointment must be attended as scheduled. Each delayed or missed appointment will prolong the time necessary to complete treatment (which can never be precisely determined) and may create problems making it impossible to achieve the desired results.

2. Instructions must be diligently followed. There will be instructions given concerning special oral hygiene measures which must be followed. Also, as treatment progresses, certain adjunctive appliances may be necessary. Instructions will be given as to their care and use which must also be followed exactly. Informational and instructional literature will be given. It is the responsibility of the patient to thoroughly study and understand this material.

3. Decalification (permanent markings on the teeth), decay, and/or gum disease can occur if teeth are not brushed properly and thoroughly during the treatment period. Sweets and between meal snacks must be eliminated. If desired results are to be achieved, this is absolutely necessary. Continuing checkups and dental care from the patient’s general dentist during the course of treatment is essential.

4. Teeth may become non-vital. This is always a possibility, with or without orthodontic treatment. Trauma from a blow, deep fillings, etc. may cause the nerve tissue in a tooth to die. This can happen over a long period of time. Even though this problem may exist, it may be undetectable at the beginning of orthodontic treatment, but through tooth movement it may exhibit itself. Root canal treatment may then become necessary in order to preserve the tooth or teeth.

5. Root resorption is a condition where roots may become shortened during treatment. Under healthy conditions, this is no serious disadvantage. However, if gum disease occurs in later life, the longevity of the teeth could be compromised. Other conditions can cause root resorption such as: trauma, cuts, impaction, endocrine disorders, or idiopathic (unknown) reasons.

6. Temporomandibular Joint (TMJ) dysfunction can occur before, during or after orthodontic treatment. Many times the TMJ, even though the damage had begun long before the orthodontic treatment, because of the subtle changes in the bite through treatment, symptoms of this damage such as clicking, popping, crackling, pain, headaches, etc., may then become evident. Even though there were no apparent symptoms previously, these may begin to exhibit themselves during treatment. Should such symptoms occur, it may be necessary for the patient to be referred to a TMJ specialist.

7. Shifting of teeth might occur after braces are removed. For this reason, retainers are constructed which must be diligently worn for a period of time which will vary between patients. Retainers are made of materials that are subject to breakage no matter how well constructed. Retainers must be handled and used carefully. Repair charges may be made. Instructions will be given concerning these appliances.

8. I recognize that it is my responsibility to follow instructions completely and seek attention in a timely manner should any unexpected problems occur by informing this office immediately. I must explicitly follow any instructions, either written or oral, which have
been given to me relating to this orthodontic treatment.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of orthodontic treatment and have received answers to my satisfaction. I have been given the alternative of seeking care with an orthodontic specialist. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning any results from treatment. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I accept all terms and conditions expressed within it and freely give my consent to authorize Dr. ___________________________ and any and all associates necessary in rendering services that he/she deems necessary or advisable for this subject orthodontic treatment.

Patient’s name (please print)  Signature of patient, legal guardian  Date
or authorized representative

Witness to signature  Date

(Rev. 1/1/96)
Orthodontics

POTENTIAL RISKS AND LIMITATIONS OF ORTHODONTIC TREATMENT

To our patients,

As a rule, excellent orthodontic results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These are seldom enough to contraindicate treatment but should be considered in making the decision to wear orthodontic appliances. Please feel free to ask any questions about this at the pretreatment consultation.

Decalcification (permanent markings), decay, or gum disease can occur if patients do not brush their teeth properly and thoroughly during the treatment period. Excellent oral hygiene and plaque removal is a must. Sugars and between meal snacks should be eliminated. Regular dental visits should be maintained.

Teeth have a tendency to rebound to their original position after orthodontic treatment. This is called relapse. Very severe problems have a tendency to relapse and the most common area for relapse is the lower front teeth. After removal of the braces, retainers are placed to minimize relapse. Full cooperation in wearing these appliances is vital. We will make our correction to the highest standards and in some cases overcorrect in order to accommodate the rebound tendencies. When retention is discontinued some relapse is still possible.

A nonvital or dead tooth is a possibility. A tooth that has been traumatized from a deep filling or even a minor blow can die over a long period of time with or without orthodontic treatment. An undetected nonvital tooth may flare up during orthodontic movement, requiring endodontic (root canal) treatment to maintain it. Under healthy circumstances the shortened roots are no disadvantage. However, in the event of gum disease in later life the root resorption could reduce the longevity of affected teeth. It should be noted that not all root resorption arises from orthodontic treatment. Trauma, cuts, impaction, endocrine disorders, or idiopathic reasons can also cause root resorption.

There is also a risk that problems may occur in the temporomandibular joints (TMJ). Although this is rare, it is a possibility. Tooth alignment or bite correction can improve tooth-related causes of TMJ pain but not in all cases. Tension appears to play a role in the frequency and severity of joint pains.

Occasionally a person who has grown normally and in average proportions may not continue to do so. If growth becomes disproportionate, the jaw relation can be affected and original treatment objectives may have to be compromised. Skeletal growth disharmony is a biological process beyond the orthodontist’s control.

The total time for treatment can be delayed beyond our estimate. Lack of facial growth, poor elastic wear, lack of cooperation, broken appliances and missed appointments are all important factors which could lengthen treatment time and affect the quality of the result.

So please, let’s make every effort to do it right. This takes cooperation from everyone - the doctors, the staff, your family, and, most of all, the patient.

We are thanking you in advance for your cooperation in this matter.

I have read and reviewed the above discussion of the potential risks of orthodontic treatment. If I did not understand any of the risks described, I will discuss my questions with the doctor prior to beginning orthodontic treatment.

DATE SIGNATURE
THE PURPOSE and NECESSITY for placing POSTS and/or RETENTION PINS in teeth occurs when there is so little natural tooth structure remaining that with usual dental treatment procedures it would not be possible to preserve the tooth in either a vital or non-vital state. It then becomes necessary to place either pins or posts into the remaining tooth structure to form a substructure onto which a large filling or crown may be placed to restore and preserve the tooth. This type of treatment may help avoid extracting the remaining tooth structure together with its roots and possibly avert artificial replacement.

I UNDERSTAND that the placement of POSTS and/or RETENTION PINS which are often necessary to be placed when there is inadequate tooth structure remaining to support restoration of a particular tooth or teeth may include possible inherent risks such as but not limited to the following, including no promises or guarantees as to the desired results which may or may not be achieved:

1. **Root canal treatment**: Even though the tooth is badly broken down, the nerve tissue may still be vital and it is best in most cases to maintain the tooth in a vital state rather than remove the vital nerve tissue. Because of the lack of tooth structure, in many cases, pins can be placed in the remaining tooth structure to support the restoration of the tooth. However, at times these pins may impinge on the remaining nerve tissue and cause it to degenerate, requiring nerve removal and root canal treatment.

2. **Crown or root fracture**: At times, particularly when a tooth has been endodontically treated (having bad root canal treatment), the remaining tooth or root structure may have become brittle due to undermined or reduced tooth structure. When inserting either pins or posts necessary for retention of a large filling or crown, fracturing or splitting may occur, which in most cases will necessitate extraction of the tooth, making replacement with a bridge or implant necessary.

3. **Perforation**: When posts or pins are inserted, there is the possibility of perforating a root of the tooth, or, in some cases, the pulp chamber. Should this occur, it is possible in some cases to repair the perforation which may require being referred to a specialist. However, if this is not possible it may be necessary to extract the tooth and replace it with a bridge or implant. If a bridge abutment or crowned tooth requires post placement, the chance for perforation is increased due to obscured anatomy.

4. **Numbness**: There is the possibility of injury to the nerves of the face or tissues of the oral cavity during the administration of anesthetics or during treatment procedures which may cause a numbness of lips, tongue, tissues of the mouth, and/or facial tissues. This numbness is usually temporary, but, rarely, may be permanent.

5. **Looseness or breakage**: There may be the possibility of the pins or posts becoming loose or even breaking which could cause the restoration to dislodge. This occurrence could be the result of chewing excessively hard materials, changes in biting forces, traumatic blows to the mouth, etc. The dislodging of the restoration may have appeared to occur when chewing something soft, or for no apparent reason, whereas the loosening or breaking of the pins or posts actually took place earlier for the above reasons.

6. **Tenderness, soreness or sensitivity**: These are all possibilities when teeth are required to be treated with pins or posts. Should any of these symptoms persist, it is necessary to contact this office for an examination.
7. I acknowledge that it is my responsibility to seek attention should any undue problems occur after treatment. I shall diligently follow any preoperative and postoperative instructions given to me.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of placing pins and/or posts in teeth and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fare(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr._______________________________ and/or any associates to render that treatment necessary or advisable to my dental conditions, including the administration and/or prescribing of any and all anesthetics and/or medications.

Patient’s name (please print)  Signature of patient, legal guardian or authorized representative  Date

Witness to signature  Date

(Rev. 12/9/96)
I understand that undergoing I.V. SEDATION/ANESTHESIA includes possible inherent risks such as, but not limited to the following:

1. Complications due to drugs and anesthesia, which include but are not limited to: tenderness, bruising, nausea, vomiting, swelling, bleeding, infection, numbness, allergic reaction, stroke, and heart attack. Some of these complications, although rare, may require hospitalization and may even result in death.

2. Bruising or tenderness of the I.V. induction site may occur. Some sedative agents may cause a burning or itching sensation in the wrist or arm during induction. Edema may be caused when excess I.V. sedation fluid enters surrounding tissues and may take several days to resolve. Tenderness/edema can be treated with warm moist heat applied to the site.

3. Need for limitation of food and drink. I understand that the patient must refrain from any food or drink after midnight for a morning appointment. Prior to an afternoon appointment the patient is limited to a light breakfast no later than six hours before treatment time and clear liquids up to three hours before treatment.

4. Changes in health are important, including fevers or cold. I am expected to convey this information to the dentist prior to a planned appointment when I.V. sedation/anesthesia are involved.

5. A responsible adult must accompany the patient at the time of discharge, and I understand that the patient must not drive a vehicle or take a bus or taxi after undergoing I.V. sedation/anesthesia.

6. Women: Anesthetics, medications and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion, and I accept full responsibility for informing the dentist or attending anesthesiologist or anesthetist of a suspected or confirmed pregnancy.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of I.V. sedation/anesthesia and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, or even death which may be associated with any phase of receiving I.V. sedation/anesthesia in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr._____________________________ and/or his/her associates to render any treatment necessary or advisable to my dental...
conditions, including any and all anesthetics and/or medications, for my own benefit or the benefit of my minor child or ward.

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INFORMATIONAL PURPOSES ONLY

SILVER AMALGAM RESTORATIONS

I UNDERSTAND that placing of SILVER AMALGAM FILLINGS includes possible inherent risks. Furthermore, no promises or guarantees of results can be made or should be expected.

These risks include, but are not limited to the following:

1. Silver amalgam has been used for decades as a filling material for teeth and there are no proven scientific studies accepted by the American Dental Association which supports the belief by some opponents to the material that there is a possibility, although unproven, that silver amalgam may have an effect on the general health of a person due to its mercury content. However, silver amalgam continues to be endorsed by the ADA as an acceptable filling material.

2. The teeth treated may remain sensitive or even possibly quite painful both during and after completion of treatment. If the pain is severe or extreme sensitivity persists for an extended period of time, please call the office for an examination.

3. Numbness: There may be a numbness in the tongue, lips, teeth, jaws, and/or facial tissues resulting from the anesthetic administration or other treatment procedures. If this numbness persists for a period of time longer than 24 hours, please call the office.

4. Fracture or breakage: Should a tooth require a large amalgam filling because of the extent of the decay or for other reasons, there is a possibility of the filling breaking or loosening. It may then be required to place a crown in order to preserve the tooth. If the tooth structure retaining the filling breaks, it may also be necessary to crown the tooth in order to preserve it.

5. Root canal or Extraction: Should the decay have invaded the tooth to the extent that even after it has been filled, it remains or becomes excessively painful, it may be necessary to either perform root canal treatment or possibly even extract the tooth.

6. Fragility of Silver Amalgam: Silver amalgam is quite fragile until it has completely solidified. If is necessary to avoid chewing on recently placed amalgam fillings for approximately 24 hours.

7. Amalgam tattoos: Occasionally shavings generated by placement or carving of silver amalgam fillings may work their way into the surrounding gum tissues and become lodged. Over an extended period of time gray spots or tattoos may become visible within the mouth.

8. I understand that it is my responsibility to notify this office should any undue or unexpected problems occur or if I experience any problems relating to the treatment rendered or the services performed.
INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of silver amalgam fillings and have received answers to my satisfaction. I do voluntarily assume any and all possible risks including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises of guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr.______________________________ and/or his/her associates or agents to render any treatment necessary and/or advisable to my dental conditions, including the administration and/or prescribing of any medications.

Patient’s name (please print)  Signature of patient, legal guardian or authorized representative  Date

Witness to signature  Date

(Rev. 4/00)
Patient Acknowledgment and Refusal of Periodontal Treatment

I have been advised by Dr. _______________ that I have an active periodontal infection in my mouth. My diagnosis, recommended treatment and prognosis have been reviewed with me in detail. I realize that periodontal disease is an infection of the gum tissue which destroys the bone support of my teeth. My refusal of periodontal treatment may lead to further bone loss, eventual tooth loss and has been associated with other diseases such as heart disease, strokes and other general health complications. I have had the opportunity to ask questions that were answered to my satisfaction.

With my signature, I DECLINE treatment and accept the consequences of my decision to decline periodontal treatment.

Patient Signature ______

Date

Witness
Orthodontics

POTENTIAL RISKS AND LIMITATIONS
OF ORTHODONTIC TREATMENT

To our patients,

As a rule, excellent orthodontic results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These are seldom enough to contraindicate treatment but should be considered in making the decision to wear orthodontic appliances. Please feel free to ask any questions about this at the pretreatment consultation.

Decalcification (permanent markings), decay, or gum disease can occur if patients do not brush their teeth properly and thoroughly during the treatment period. Excellent oral hygiene and plaque removal is a must. Sugars and between meal snacks should be eliminated. Regular dental visits should be maintained.

Teeth have a tendency to rebound to their original position after orthodontic treatment. This is called relapse. Very severe problems have a tendency to relapse and the most common area for relapse is the lower front teeth. After removal of the braces, retainers are placed to minimize relapse. Full cooperation in wearing these appliances is vital. We will make our correction to the highest standards and in some cases overcorrect in order to accommodate the rebound tendencies. When retention is discontinued some relapse is still possible.

A nonvital or dead tooth is a possibility. A tooth that has been traumatized from a deep filling or even a minor blow can die over a long period of time with or without orthodontic treatment. An undetected nonvital tooth may flare up during orthodontic movement, requiring endodontic (root canal) treatment to maintain it. Under healthy circumstances the shortened roots are no disadvantage. However, in the event of gum disease in later life the root resorption could reduce the longevity of affected teeth. It should be noted that not all root resorption arises from orthodontic treatment. Trauma, cuts, impaction, endocrine disorders, or idiopathic reasons can also cause root resorption.

There is also a risk that problems may occur in the temporomandibular joints (TMJ). Although this is rare, it is a possibility. Tooth alignment or bite correction can improve tooth-related causes of TMJ pain but not in all cases. Tension appears to play a role in the frequency and severity of joint pains.

Occasionally a person who has grown normally and in average proportions may not continue to do so. If growth becomes disproportionate, the jaw relation can be affected and original treatment objectives may have to be compromised. Skeletal growth disharmony is a biological process beyond the orthodontist’s control.

The total time for treatment can be delayed beyond our estimate. Lack of facial growth, poor elastic wear, lack of cooperation, broken appliances and missed appointments are all important factors which could lengthen treatment time and affect the quality of the result.

So please, let’s make every effort to do it right. This takes cooperation from everyone - the doctors, the staff, your family, and, most of all, the patient.

We are thanking you in advance for your cooperation in this matter.

I have read and reviewed the above discussion of the potential risks of orthodontic treatment. If I did not understand any of the risks described, I will discuss my questions with the doctor prior to beginning orthodontic treatment.

DATE

SIGNATURE
CONSENT FOR ORAL SURGERY

Patient Name: ________________________________  Date: _______________

Proposed Operation: ____________________________________________________________

This is my consent to the oral and maxillofacial surgery. I agree to the use of: (check one)

________ local anesthesia  ________ intravenous sedation

________ inhalation sedation  ________ ambulatory general anesthesia

There are possible complications of the surgery, drugs, and anesthesia. The more common complications are pain, infection, swelling, bleeding, or discoloration. There can also be pain or inflammation from injection into a vein. There is a possibility of injury to or stiffness of the facial muscles or the jaw. There is also the possibility of injury to adjacent teeth, restorations, or other tissues, referred pain to the ear, neck or head, nausea, vomiting, allergic reactions, bone fractures, and delayed healing. Sinus complications may also occur which might include an opening into the sinus from the mouth with the removal of upper teeth. Temporary or permanent numbness of the lip or tongue may occur following removal of lower teeth associated with these nerves.

Medications have the potential to cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol and other drugs. I agree not to operate any motor vehicle or hazardous machinery for a 24-hour period following the use of intravenous sedation. In addition, I understand that pain medication may also cause drowsiness, lack of awareness, and problems of coordination.

I understand I will receive appropriate post-operative instructions and will be given an appointment date to return for observation. There is no warranty or guarantee as to any result and/or cure. I understand that I can ask any questions regarding the procedure including a detailed explanation of the complications.

______________________________  ________________________________
Date   (Signature of patient or person with authority to consent for patient)

______________________________
Date   (Witness)
WAIVER AND CONSENT

I, __________________________ the undersigned, do hereby authorize and consent to the use of certain photographs/x-rays of me taken by __________________________. I hereby grant them permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official medical publication or in the form of prints, slides or film for use in connection with articles and lectures dealing with jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without my express consent in each instance.

NO FULL-FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT FOR EACH ONE.

Polaroid photography taken during treatment are used by our laboratories for cosmetic purposes for the fabrication of your crowns, bridges or dentures and are a part of your permanent dental record.

Patient’s Signature and/or Guardian

Patient’s Address

Date

Please initial one of the following, after carefully reading and understanding:

- I do not consent to the use of slides or photography for use in dental education or publications.
- I do consent to the use of slides or photographs for use in dental education or publications.
- I do consent to the use of slides or photography EXCEPT full-face or identifying views.
CONSENT FOR DENTAL/ORAL SURGICAL TREATMENT IN PATIENTS WHO HAVE RECEIVED BISPHOSPONATE DRUGS

Patient Name: ___________________________ Patient Chart #: ___________________________

Today’s Date: ____________________________

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

Having been treated previously with bisphosphonate drugs you should know that there is a risk of future complications associated with dental treatment. Bisphosphonate drugs appear to adversely affect the ability of bone to break down or remodel itself thereby reducing or eliminating the ordinary excellent healing capacity of bone. This risk is increased after surgery, especially from extraction; implant placement or other invasive procedures that might cause even mild trauma to bone. Osteonecrosis may result. This is a smoldering, long-term, destructive process in the jawbone that is often very difficult or impossible to eliminate.

Your medical/dental history is very important. We must know the medications and drugs that you have received or taken or are currently receiving or taking. An accurate medical history, including names of physicians is important.

1. Antibiotic therapy may be used to help control possible post-operative infection. For some patients, such therapy may cause allergic responses or have undesirable side effects such as gastric discomfort, diarrhea, colitis, etc.

2. Despite all precautions, there may be delayed healing, osteonecrosis, loss of bony and soft tissue, pathologic fracture of the jaw, oral-cutaneous fistula, or other significant complications.

3. If osteonecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy including hospitalization, long-term antibiotics, and debridement to remove non-vital bone. Reconstructive surgery may be required, including bone grafting, metal plates and screws, and/or skin flaps and grafts.

4. Even if there are no immediate complications from the proposed dental treatment, the area is always subject to spontaneous breakdown and infection. Even minimal trauma from a toothbrush, chewing hard food, or denture sores may trigger a complication.

5. Long-term post-operative monitoring may be required and cooperation in keeping scheduled appointments is important. Regular and frequent dental checkups with your dentist are important to monitor and attempt to prevent breakdown in your oral health.

6. I have read the above paragraphs and understand the possible risks of undergoing my planned treatment. I understand and agree to the following treatment plan:

7. I understand the importance of my health history and affirm that I have given any and all information that may impact my care. I understand that failure to give true health information may adversely affect my care and lead to unwanted complications.

8. I realize that, despite all precautions that may be taken to avoid complications; there can be no guarantee as to the result of the proposed treatment.

I certify that I speak, read, and write English, or, have used a translator to explain all of the previous information to me and I understand all of the information translated to me. I give my permission and consent to the procedure(s) proposed. I have had all of my questions answered and all necessary information has been completed on this form prior to my initials or signature.

Patient=s (or Legal Guardian=s) Signature Date

Doctor=s Signature Date
INFORMATIONAL INFORMED CONSENT

TEMPORARY DENTURE AGREEMENT

I, [Patient Name], understand and agree to the following:

Temporary dentures(s) will be fitted shortly after surgery.

These temporary dentures(s) are meant to be used to aid in the 2-3 month healing period.

The aesthetics (appearance), bit, fit, and function are, and will be approximations of what is possible for a long-term denture(s), and I accept these limitations.

Two chair-side liners and two adjustments of the temporary denture(s) are included. However, any resetting or remaking of the temporary denture(s), for whatever reason, will result in additional charges.

Patient [Name] Date
I UNDERSTAND that ROOT CANAL THERAPY includes possible inherent risks such as, but not limited to, the following: (I understand that no promises or guarantees of results have been made nor are implied)

1. The treated tooth may remain tender or even quite painful for a period of time, both during and after completion of therapy. If pain is severe or swelling occurs, it is imperative to call our office immediately. There is also a possibility to numbness occurring and/or persisting in the tongue, lips, teeth, jaws and/or facial tissues which may be a result of the anesthetic administration or from treatment procedures. This numbness is usually temporary, but rarely, could be permanent.

2. In some teeth, conventional root canal therapy may not be sufficient. If the canals are calcified, roots excessively curved or inaccessible, inadvertent pulp chamber or root perforation may occur, requiring referral to a specialist. If there is infection in the bone surrounding the tooth healing may be prolonged and/or referral to a specialist for retreatment, extraction or a surgical apicoectomy may become necessary. In unusual cases, hospitalization or I.V. antibiotics may be necessary to treat an endodontic infection.

3. Root canal treated teeth must be protected. During and after treatment, your tooth in most instances, will have only a temporary filling. Should this come out during or after treatment, you must contact our office immediately to arrange for replacement. Root canal treated teeth may become brittle and, due to undermined or reduced tooth structure, may be subject to cracking or fracturing. Crowning or capping the treated tooth is the best precautionary measure to help avoid this from occurring; this procedure should be performed as soon as possible after treatment.

4. Root canal therapy is not always successful. Many factors influence success: adequate gum tissue attachment and bone support; oral hygiene; previous and present dental care; general health; trauma; pre-existing undetected root fractures, accessory or lateral canals; etc. It may be difficult to place filling material to the end of the tooth (underfill) or some filling material may extrude from the tooth (overfill), which can, in some cases cause inflammation, nerve damage resulting in temporary or in rare cases, permanent numbness of the lip. Surgery may be required to remove excess filling material or residual infection. Even though a tooth may have appeared to be successfully treated, there is always the possibility of failure making additional root surgery (apicoectomy) or extraction necessary. If a bridge abutment or crowned tooth requires endodontic therapy, the change for perforation is enhanced due to obscured anatomy.

5. A crown abutment or crown (cap) may be damaged or destroyed during rubber dam application, access preparation, or other procedures as part of endodontic therapy. Porcelain is particularly susceptible to fracture or cracking, and an existing porcelain crown may have to be remade, particularly if the pre-existing crown is all-porcelain in design.

6. Root fracture is one of the primary reasons for root canal failure. Unfortunately, hairline cracks are almost always invisible and undetectable. Causes of root fracture are trauma, inadequately protected teeth, initial cracking of the coronal portion of the tooth, pre-existing large fillings, improper bit, excessive wear, habitual grinding of teeth, etc. Root fracture after or prior to treatment usually necessitates extraction.

7. There are alternative to root canal treatment. These alternatives (though not of choice) include: no treatment; extraction, extraction followed by bridge or partial denture placement; and/or extraction followed by implant and crown placement.

8. Because of the fragility and small diameter of root canal instruments used in root canal treatment, there exists the possibility of instrument separation (breakage) which may or may not be detected at time of treatment. Although it is often possible to bypass or incorporate separated instruments within the filling material, instrument separation may result in the need for retreatment, surgical retrieval or extraction of the tooth.
CONSENT TO PROCEED

I authorize Dr. and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respirator system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name

Signature: ______________________________ Date: ______________________________

Patient, legal guardian or authorized agent or patient)

Witness: ______________________________ Date: ______________________________
ROOT CANAL RE-TREATMENT

I UNDERSTAND THAT ROOT CANAL RE-TREATMENT includes possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of successful results have been made.

1. A re-treated tooth may remain tender or painful for a period of time, both during and after completion of therapy. If pain is severe or swelling occurs, it is imperative to call our office immediately. There is also the possibility of numbness occurring and/or persisting in the tongue, lips, teeth, jaws and/or facial tissues which may be a result of the anesthetic administration or from treatment procedures. This numbness is usually temporary, but, rarely, could become permanent.

2. Extensive complication treatment may be necessary. When re-treatment is necessary, the removal of the previous root canal filling material may involve difficulties such as pulp chamber or root perforation, root fracture, or other complications. This may possibly necessitate referral to a specialist or may even require extraction of the tooth.

3. Instrument separation may occur. Because of the small diameter and fragility of root canal instruments, there is a possibility of an instrument separating or breaking. Many times the separated part of the instrument can be removed or even retained within the tooth structure without causing problems. No matter how carefully instruments are manipulated the possibility of separations exists.

4. Root canal re-treatment is not always successful. Many factors influence success: degree of residual infection; adequate gum tissue attachments and bone support; oral hygiene; previous and present dental care; general health; trauma; pre-existing undetected root fractures; accessory or lateral canals; etc. It may be difficult to place filling material to the end of the tooth (underfill) or some filling material may extrude from the tooth (overfill), which can, in some cases cause inflammation, nerve damage resulting in temporary, or in rare cases, permanent numbness of the lip. Surgery may be required to remove excess filling material. Even though a tooth may have appeared to be successfully retreated, there is always the possibility of failure making additional re-treatment, additional root surgery (apicoectomy) or extraction necessary. If a bridge abutment or crowned tooth requires endodontic re-treatment, the chance for perforation is enhanced due to obscured anatomy. It is more difficult to achieve success following re-treatment than after initial treatment.

5. A previously treated tooth may subsequently become infected. Should this occur, it may be difficult to control the infection with re-treatment only of the root canal and/or administration of antibiotics. The tooth may require a procedure called an apicoectomy that entails surgical removal of the end of the root and placement of filling material. In most instances, this treatment will take care of the problem. However, at times this procedure may not produce the desired result and preservation of the tooth may not be possible. Infections can sometimes be hard to control and hospitalization may become necessary.

6. A crown abutment or crown (cap) may be damaged or destroyed during rubber dam application, access preparation, or other procedures as part of endodontic therapy. Porcelain is particularly susceptible to fracture or cracking, and an existing porcelain crown may have to be remade, particularly if the pre-existing crown is all-porcelain in design. If no cap is in place, after treatment the tooth will remain brittle and will need to be preserved with a crown build-up and crown to prevent fracture loss.
INFORMATIONAL INFORMED CONSENT

Final Approval for Denture Construction

I accept the placement, arrangement, size and color of the denture teeth.

I accept the occlusion (bite).

I understand that the processing (conversion from wax to acrylic) of my dentures will result in a better fit than that experienced with the wax try-in dentures.

I am aware that my initial speech and eating experiences will be different and will feel and function normally as my mouth and tongue adjusts to the new dentures.

I also understand that unpredictable gum contours and/or levels can change in the future for which there may be no remedy.

I accept that there can be no changes to the dentures after today without additional expense to me.

I acknowledge that my follow-up care includes a 30-day adjustment period with 3 free adjustments; not to exceed 30 minutes each.

Signature: ________________________________________________________________

Witness: _________________________________________________________________

Date: ___________________________________________________________________
Denture Service

Congratulations! You are embarking on a journey of acquiring a more attractive smile. Your new dentures will be designed to complement your facial characteristics, and consequently, you can expect that people who see you will perceive your new teeth as real, and not artificial. In most cases, improved fit and function are experienced as well. Doctor and staff at ____________________________ are committed to doing their best work for you and making your experience here enjoyable.

The process takes about 3 weeks to complete, and involves at least 5 appointments:

1. Planning, facial measurements, impressions, tooth color and selection. - 1 hour.
3. Centric relation and vertical dimension determination. - 1 hour.
4. Try-in wax dentures for bite, speech, and appearance check. - 1 hour.
5. Fit completed dentures, photographic records. - 1 hour.

An adjustment period of 30 days is included with your denture service.

Your dentures will feel, fit and function differently from any previously worn dentures. This is because of improvements in the relationships of teeth, denture bases, occlusal position, opening (bite), and improvements in the relationship of the dentures to your muscle attachments, temporomandibular joints, and facial form. Every effort will be made to make you as comfortable as possible as you adapt to your new dentures. This usually occurs within 30 days.

Your speech may sound different, or be difficult at first with your new dentures. This will return to normal in time, usually 1-2 weeks. This can be accelerated by reading out loud to yourself several times a day.

Lower dentures do not have the retention and stability experienced with upper dentures. This is because of the absence of a broad denture bearing surface like we see on the palate of uppers. Many patients elect to use a denture adhesive with the lower denture for enhanced security and function. An implant retained lower denture can be the answer for those requiring maximum retention. The doctor will discuss the procedures involved and the costs with you if you want to pursue this option.

Denture service fee is for the doctor’s time only. You may request additional appointments for any phase of your denture service, and these may be charged separately at the doctor’s discretion. The doctor may require additional appointments to achieve his objectives, and you will not be charged for any of these.

You may terminate your denture service at any time, for any reason and you will be financially responsible only for that portion of the doctor’s time used. There are no refunds after dentures are delivered.

The doctor reserves the right to terminate the denture service if his instructions are not followed, or if a negative emotional climate is imposed on the doctor or staff through behavior, or attitude, in which case patient will be financially responsible only for that portion of the doctor’s time used.

We here at ____________________________ look forward to working with you. We pride ourselves in the work and service we provide and it is our hope that you enjoy your experience with us.

I have read, understand, and accept the above parameters of my denture service.

Signature___________________________________ Date_________________________
INFORMATIONAL USE ONLY

PATIENT INFORMATION AND CONSENT FORM FOR COSMETIC DENTISTRY / COSMETIC RECONSTRUCTION

Patient: __________________________________________________________

Date: __________________________________________________________

1. I, __________________________, authorize and request Dr. (s) ________________________ and/or such assistants as may be selected by him (them) to provide cosmetic dentistry / cosmetic reconstruction to address the conditions or symptoms based on the diagnostic studies and/or evaluations already performed and which have been explained to me: ________________________________

   (Explain nature of conditions, e.g. missing teeth, malposed teeth, irregular alignment, improper color, excessive wear, missing teeth or inability to wear previous dentures or patients = desire to use an implant).

2. I also authorize and direct my doctor(s), with associates or assistants of his (their) choice, to provide such additional services as he (they) may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents, the performance of necessary laboratory, radiological (x-ray), and other diagnostic procedures; and the administration of medications orally, by injection, by infusion, or by any other dentally accepted route of administration. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my doctor(s), with associates or assistants of his (their) choice, to do whatever he (they) deem necessary and advisable under the circumstances, including the decision not to proceed with the cosmetic treatment.

3. Alternatives to cosmetic dentistry / cosmetic reconstruction have been explained to me, including their risks. I have considered these alternatives to treatment and their risks but I request the cosmetic dentistry/cosmetic reconstruction knowing the treatment is in part elective and cosmetic and not due to any breakdown of my teeth. I consent to the tooth reduction or loss of tooth structure necessary to accomplish the cosmetic requirements I would like to have.

4. I am aware that the practice of dentistry and cosmetic dentistry/cosmetic reconstruction is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my cosmetic dentistry/cosmetic reconstruction and the associated treatment and procedures. I am aware that there is a risk that the cosmetic dentistry/cosmetic reconstruction will require ongoing maintenance care, remaking of crowns, bridges and veneers and the longevity is directly related to what I eat and drink and my home-care habits.

5. The cosmetic dentistry/cosmetic reconstruction procedure has been explained to me and I understand the nature of these procedures and anesthetic to be used as follows: ______________

   (Description in layman terms of the specific cosmetic procedure and anesthetic to be used).

6. As with any dental procedure, there are possible complications of which you must be aware. These include, but are not limited to: limited oral function; post operative pain; bleeding; infection or abscess which may require treatment or drainage; temporary bruising of the face, allergic reactions to metal and medications; a change in sensation or numbness to the lip, chin, face and/or tongue which may be of a temporary or permanent nature; periodontal infection or condition requiring additional treatment; injury to the teeth; temporomandibular joint (jaw) problems requiring additional treatment and poor healing which may result in an alteration or change in the planned treatment. I have also been advised that there is a risk that the crowns, veneers and bridges may break which could require additional procedures to correct.
7. I understand that some or all of the cosmetic dentistry/cosmetic reconstruction is elective and only done for my cosmetic interest but there are dental conditions that if left untreated, the following may occur: limited oral function; gum or bone disease, loss of bone; inflammation; infection; sensitivity; looseness and/or loss of teeth; shifting of teeth with bite changes; temporomandibular joint (jaw) problems and an inability to have the same treatment, but due to the changes in the oral conditions or medical conditions, additional and more extensive treatment will have to be considered.

8. I have been advised that the use of tobacco, coffee, alcohol or sugar and some prescription drugs will limit the cosmetic success of the treatment and require additional treatment to correct the problems. The reasons may include but not only limited to staining, decreased tissue health, periodontal disease, recurrent decay and fracture of teeth and restorations. Because there is no way to accurately predict the capabilities of each patient, I agree to follow my doctor=s home care instructions and to report to my doctor for regular examinations, professional dental cleaning and maintenance as instructed.

9. I agree not to operate a motor vehicle or hazardous device for at least _______ hours or more until fully recovered from the effects of the anesthesia or drugs given of my care as selected by my doctor.

10. I understand I have had an opportunity to ask and have my questions answered. I understand my insurance may or may not cover dentistry for cosmetic reasons and I am responsible for all dental treatment regardless of my insurance plan.

11. To my knowledge I have given an accurate report of my physical, dental and mental health history. If I am currently in treatment for any health problems I certify that I have discussed the proposed treatment with my health care provider and have received his or her consent to undergo this cosmetic procedure.

12. I certify that I have read, have had explained to me, and fully understand the foregoing consent to cosmetic dentistry, drug and anesthetic procedures, and that it is my intention to have the foregoing carried out as stated. I have been advised of information concerning the longevity of the cosmetic procedures. However, I have discussed this as well as the nature of the services and procedures and I consent to the cosmetic dentistry/cosmetic reconstruction knowing its risks and limitations.

Date

Witness (if available)

Parent or Guardian (if patient is a minor)

Dated : ___________________________ Time : ___________________________
I UNDERSTAND that ROOT CANAL THERAPY includes possible inherent risks such as, but not limited to, the following: (I understand that no promises or guarantees of results have been made nor are implied)

1. **The treated tooth may remain tender or even quite painful** for a period of time, both during and after completion of therapy. If pain is severe or swelling occurs, it is imperative to call our office immediately. There is also a possibility of numbness occurring and/or persisting in the tongue, lips, teeth, jaw, and/or facial tissues which may be a result of the anesthetic administration or from treatment procedures. This numbness is usually temporary, but, rarely, could be permanent.

2. **In some teeth, conventional root canal therapy may not be sufficient.** If the canals are calcified, roots excessively curved or inaccessible, inadvertent pulp chamber or root perforation may occur, requiring referral to a specialist. If there is infection in the bone surrounding the tooth healing may be prolonged and/or referral to a specialist for retreatment, extraction or a surgical apicoectomy may become necessary. In unusual cases, hospitalization or I.V. antibiotics may be necessary to treat an endodontic infection.

3. **Root canal treated teeth must be protected.** During and after treatment, your tooth in most instances will have only a temporary filling. Should this come out during or after treatment, you must contact our office immediately to arrange for a replacement. Root canal treated teeth may become brittle and, due to undermined or reduced tooth structure, may be subject to cracking or fracturing. Crowning or capping the treated tooth is the best precautionary measure to help avoid this from occurring; this procedure should be performed as soon as possible after treatment.

4. **Root canal therapy is not always successful.** Many factors influence success: adequate gum tissue attachment and bone support; oral hygiene; previous and present dental care; general health; trauma; pre-existing undetected root fractures, accessory or lateral canals; etc. It may be difficult to place filling material to the end of a tooth (under fill) or some filling material may extrude from the tooth (overfill), which can, in some cases cause inflammation, nerve damage resulting in temporary or in rare cases, permanent numbness of the lip. Surgery may be required to remove excess filling material or residual infection. Even though a tooth may have appeared to be successfully treated, there is always the possibility of failure making additional root surgery (apicoectomy) or extraction necessary. If a bridge abutment or crowned tooth requires endodontic therapy, the chance for perforation is enhanced due to obscured anatomy.

5. **A crown abutment or crown (cap) may be damaged or destroyed** during rubber dam application, access preparation, or other procedures as part of endodontic therapy. Porcelain is particularly susceptible to fracture or cracking and an existing porcelain crown may have to be remade, particularly if the preexisting crown is all-porcelain in design.

6. **Root fracture is one of the primary reasons for root canal failure.** Unfortunately, hairline cracks are almost always invisible and undetectable. Causes of root fracture are trauma, inadequately protected teeth, initial cracking of the coronal portion of the tooth, pre-existing large filling, improper bite, excessive wear, habitual grinding of teeth, etc. Root fracture after or prior to treatment usually necessitates extraction.
7. **There are alternatives to root canal treatment.** These alternatives (though not of choice) include: no treatment; extraction; extraction followed by bridge or partial denture placement; and/or extraction followed by implant and crown placement.

8. **Because of the fragility and small diameter or root canal instruments** used in root canal treatment, there exists the possibility of instrument separation (breakage) which may or may not be detected at time of treatment. Although it is often possible to bypass or incorporate separated instruments within the filling material, instrument separation may result in the need for re-treatment, surgical retrieval or extraction of the tooth.

9. **Medications.** Analgesics and/or antibiotics may need to be prescribed depending on symptoms and/or treatment findings. Prescription drugs must be taken according to instructions. Women on oral contraceptives must be aware that antibiotics cause contraceptives to become ineffective. Other methods of contraception must be utilized during the treatment period.

10. **Irrigants:** During root canal therapy, irrigants are used to enhance tissue removal and to disinfect the tooth. Occasionally these irrigants may enter the surrounding tissue or bone and cause pain, swelling, inflammation, and in rare cases, tissue necrosis.

11. **Long appointments.** There is the potential for long appointments to complete the procedures. And jaw muscles may be sore following the procedure. A pre-existing jaw problem (TMD) may be aggravated by endodontic re-treatment due to extended opening.

12. **ONCE TREATMENT HAS BEGUN, it is absolutely necessary that the root canal treatment must be completed.** One or more appointments may be required to complete treatment. It is the patient=s responsibility to seek attention should any unanticipated or undue circumstances occur. Also, the patient must diligently follow any and all preoperative and/or postoperative instructions given by the dentist and/or the staff.

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I have been given the option of seeking this treatment from a specialist. I do voluntarily assume any and all possible risks including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. _____________________ and/or his/her associates or agents to render any treatment necessary and/or advisable to my dental condition(s), including prescribing and administering any and all anesthetics and/or medications.

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INFORMED CONSENT
ORAL SURGERY AND DENTAL EXTRACTIONS

I UNDERSTAND that ORAL SURGERY and/or DENTAL EXTRACTIONS include possible inherent risks such as, but not limited to the following:

1. **Injury to the nerves** of the lips, the tongue, the tissues in the floor of the mouth, and/or the cheeks, etc. These possible nerve injuries can cause numbness, tingling, burning, and loss of taste in the case of the tongue which may be of a temporary nature lasting a few days, a few weeks, or could possibly be permanent.

2. **Bleeding and/or bruising**: Bleeding could last for several hours. Should it persist, particularly being severe in nature, it should receive attention and this office must be contacted. Bruising may possibly be prolonged.

3. **Dry socket** occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful. Smoking, drinking liquids through a straw and not following post-operative recommendations can increase the chances of this complication.

4. **Sinus involvement**: In some cases, the root tips of upper teeth lie in close apposition to the tissues of the sinuses. During extraction or surgical procedures, the thing bone and tissues surrounding the sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically repaired.

5. **Infection**: No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, for infections to occur postoperatively. At times these may become serious. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon as possible should be received and this office must be contacted. In some cases hospitalization and/or treatment with I.V. antibiotics may become necessary.

6. **Fractured jaw, roots or bone fragments**: There is a possibility, even though extreme
care is exercised, that the jawbone, teeth roots or bone spicules may be fractured which may require referral to a specialist for treatment. A decision may be made to leave a small piece of root or bone fragment in the jaw when its removal would require extensive surgery and/or risk of complications.

7. Injury to adjacent teeth, filling or porcelain crowns may occur no matter how carefully surgical and/or extraction procedures are performed. Fractured fillings or crowns may require replacement.

8. Bacterial endocarditis: Because of the normal existence of bacteria on the oral cavity, the tissues of the heart in some cases and due to a number of conditions may be susceptible to bacterial infection transmitted from the mouth to the heart through the circulatory system. A condition called bacterial endocarditis (an infection of the heart) may occur which can result in damage to heart valves. If any heart problems are known or suspected (such as a murmur following rheumatic fever, existence of an artificial heart valve, cardiac damage following PhenFen use, etc.), the dentist must be informed prior to surgery.

9. Muscle or jaw soreness may be noticed following oral surgery and especially third molar extractions. Pre-existing conditions affecting the jaw joints (TMJ) may be aggravated by oral surgery. Clicking, popping, muscle soreness and difficulty opening may be noticed for some time following surgery. If such symptoms or conditions persist, the patient should call our office. The patient must notify the dentist of any such pre-existing conditions prior to surgery.

10. Unusual reactions to medication given or prescribed: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to instructions. Women on oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during the treatment period.

11. Bisphophonate Drug Risks: For patients who have taken drugs such as Fosamax, Actamel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any oral surgical procedure involving bone, including extractions.
12. It is my responsibility to contact the dentist and seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative instructions given me.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option of seeking care with an oral and maxillofacial surgeon. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr.__________________ and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

_________________________ _________________________ _______    ________________
Patient’s Name (please print)       Signature of patient, legal guardian or authorized representative       Date

_____________________________   _______________
Witness to signature                       Date
INFORMATIONAL INFORMED CONSENT

ROOT CANAL RETREATMENT

I UNDERSTAND THAT ROOT CANAL RETREATMENT includes possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of successful results have been made.

1. **A retreated tooth may remain tender or painful for a period of time**, both during and after completion of therapy. If pain is severe or swelling occurs, it is imperative to call our office immediately. There is also the possibility of numbness occurring and/or persisting in the tongue, lips, teeth, jaws and/or facial tissues which may be a result of the anesthetic administration or from treatment procedures. This numbness is usually temporary, but, rarely, could become permanent.

2. **Extensive complicated treatment may be necessary.** When re-treatment is necessary, the removal of the previous root canal filling material may involve difficulties such as pulp chamber or root perforation, root fracture, or other complications. This may possibly necessitate referral to a specialist or may even require extraction of the tooth.

3. **Instrument separation may occur.** Because of the small diameter and fragility of root canal instruments, there is a possibility of an instrument separating or breaking. Many times the separated part of the instrument can be removed or even retained within the tooth structure without causing problems. No matter how carefully instruments are manipulated the possibility of separation exists.

4. **Root canal re-treatment is not always successful.** Many factors influence success: degree of residual infection; adequate gum tissue attachments and bone support; oral hygiene; previous and present dental care; general health; trauma; pre-existing undetected root fractures; accessory or lateral canals; etc. It may be difficult to place filling material to the end of tooth (under fill) or some filling material may extrude from tooth (overfill), which can, in some cases cause inflammation, additional root surgery (apicoectomy) or extraction necessary. If a bridge abutment or crowned tooth requires endodontic re-treatment, the change for perforation is enhanced due to obscured anatomy. It is more difficult to achieve success following re-treatment than after initial.

5. **A previously treated tooth may subsequently become infected.** Should this occur, it may be difficult to control the infection with re-treatment only of the root canal, and/or administration of antibiotics. The tooth may require a procedure called an apicoectomy that entails surgical removal of the end of the root and placement of filling material. In most instances, this treatment will take care of the problem. However, at times this procedure may not produce the desired result and preservation of tooth may not be possible. Infections can sometimes be hard to control and hospitalization may become necessary.

6. **A crown abutment or crown (cap) may be damaged or destroyed** during rubber dam application, access preparation, or other procedures as part of endodontic therapy. Porcelain is particularly susceptible to fracture or cracking and an existing porcelain crown may have to be remade, particularly if the pre-existing crown is all-porcelain in design. If no cap is in place. After treatment the tooth will remain brittle and will need to be preserved with a crown build-up and crown to prevent fracture loss.
7. **Root fracture** is one of the primary reasons for root canal re-treatment failure. Unfortunately, hairline cracks are almost always invisible and undetectable. Causes of root fracture trauma, inadequately protected teeth, initial cracking of the coronal portion of the tooth, pre-existing large fillings, improper bite, excessive wear, habitual grinding of teeth, etc. Root fracture after or prior to treatment usually necessitates extraction.

8. **There are alternatives to root canal re-treatment.** These alternatives (though not of choice) include: no treatment, extraction, extraction followed by a bridge or partial denture placement, and/or extraction followed by implant and crown placement.

9. **Medications.** Analgesics and/or antibiotics may need to be prescribed depending on symptoms and/or treatment findings. Prescription drugs must be taken according to instructions. Women on oral contraceptives must be aware that the antibiotics cause contraceptives to become ineffective. Other methods of contraception must be utilized during the treatment period.

10. **Irrigants.** During root canal therapy, irrigants are used to enhance tissue removal and to disinfect the tooth. Occasionally these irrigants may enter the surrounding tissue or bone and can cause pain, swelling, inflammation, and in rare cases, tissue necrosis.

11. **Long appointments.** There is the potential for long appointments to complete the procedures, and jaw muscles may be sore following the procedure. A pre-existing jaw problem (TMD) may be aggravated by endodontic re-treatment due to extended opening.

12. **ONCE TREATMENT HAS BEGUN, it is absolutely necessary that the root canal treatment must be completed.** One or more appointments may be required to complete treatment. It is the patient's responsibility to seek attention should any unanticipated or undue circumstances occur. Also, the patient must diligently follow any and all preoperative and/or postoperative instructions given by the dentist and/or the staff.

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I have been given the option of seeking this treatment from a specialist. I do voluntarily assume any and all possible risks including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may be or may not be achieved. No promises or guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. _____________________________ and/or his/her associates or agents to render any treatment necessary and/or advisable to my dental condition(s), including prescribing and administering any and all anesthetic and/or medications.

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INFORMATIONAL INFORMED CONSENT

ORAL SURGERY AND DENTAL EXTRACTIONS

I UNDERSTAND that ORAL SURGERY and/or DENTAL EXTRACTIONS include possible inherent risks such as, but not limited to the following:

1. Injury to the nerves of the lips, the tongue, the tissues in the floor of the mouth, and/or the cheeks, etc. These possible nerve injuries can cause numbness, tingling, burning, and loss of taste in the case of the tongue which may be of a temporary nature lasting a few days, a few weeks, a few months, or could possibly be permanent.

2. Bleeding, bruising, swelling: Bleeding may last several hours. Should it persist, particularly being severe in nature, it should receive attention and this office must be contacted. Bruising may possibly be prolonged.

3. Dry socket occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful. Smoking, drinking liquids through a straw and not following postoperative recommendations can increase chances of this complication.

4. Sinus involvement: In some cases, the root tips of upper teeth lie in close apposition to the tissues of the sinuses. During extraction or surgical procedures, the thin bone and tissues surrounding the sinus may be perforated. Should this occur, it may be necessary to have the sinus surgically repaired.

5. Infection: No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, for infections to occur postoperatively. At times these may become serious. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon as possible should be received and this office must be contacted. In some cases hospitalization and/or treatment with I.V. antibiotics may become necessary.
6. **Fractured jaw, roots, or bone fragments:** There is a possibility, even though extreme care is exercised, that the jawbone, teeth roots, or bone spicules may be fractured or be fractured which may require referral to a specialist for treatment. A decision may be made to leave a small piece of root or bone fragment in the jaw when its removal would require extensive surgery and/or risk of complications.

7. **Injury to adjacent teeth, fillings or porcelain crowns may occur** no matter how carefully surgical and/or extraction procedures are performed. Fractured fillings or crowns may require replacement.
8. **Bacterial endocarditis**: Because of the normal existence of bacteria in the oral cavity, the tissues of the heart in some cases and due to a number of conditions may be susceptible to a bacterial infection transmitted from the mouth to the heart through the circulatory system. A condition called bacterial endocarditis (an infection of the heart) may occur which can result in damage to heart valves. If any heart problems are known or suspected (such as a heart murmur following rheumatic fever, existence of an artificial hear valve, cardiac damage following PhenFen use, etc.), the dentist must be informed prior to surgery.

9. **Muscle or jaw soreness may be noticed following oral surgery** and especially third molar extractions. Pre-existing conditions affecting the jaw joints (TMJ) may be aggravated by oral surgery. Clicking, popping, muscle soreness and difficulty opening may be noticed for some time following surgery. If such symptoms or conditions persist, the patient should call our office. The patient must notify the dentist of any such pre-existing conditions prior to surgery.

10. **Unusual reactions to medications given or prescribed**: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to instructions. Women on oral contraceptives must be aware that all antibiotics can render these contraceptives ineffective. Caution must be exercised to utilize other methods of conception during the treatment period.

11. **It is my responsibility to contact the dentist and seek attention should any undue circumstances occur** postoperatively and I shall diligently follow any preoperative instructions given me.

**INFORMED CONSENT**: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option of seeking care from an oral and maxillofacial surgeon. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of treatment in hopes of obtaining desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this
service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr._________________________ and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetic and/or medications.

______________________________________________________________
Patient=s Name (please print)        Signature of patient, legal guardian          Date
authorized representative

Tooth No. (s)________________________

Witness to Signature          Date
IMMEDIATE COMPLETE DENTURES AND PARTIAL DENTURE

I UNDERSTAND that the process of fabricating and fitting IMMEDIATE REMOVAL PROSTHETIC APPLIANCES (PARTIAL DENTURES and/or COMPLETE ARTIFICIAL DENTURES) includes risks and possible failures. Even though the utmost care and diligence is exercised in preparation for and fabrication of immediate prosthetic appliances, there is the possibility of failure with patients not adapting to the new dentures. I agree to assume those risks and possible failures associated with but not limited to the following:

1. **Failure of immediate complete dentures:** There are many variables which may contribute to this possibility such as: (1) gum tissue which cannot bear the pressures placed upon them resulting in excessive tenderness and sore spots, especially during healing following extraction and denture placement; (2) jaw ridges which may not provide adequate support and/or retention as shrinkage occurs following extractions; (3) musculature in the tongue, floor of the mouth, cheeks etc., which may not adapt to and be able to accommodate the new artificial appliances; (4) excessive gagging reflexes as the mouth adapts to the new dentures; (5) excessive saliva or excessive dryness of mouth; (6) general psychological and/or physical problems interfering with success.

2. **Failure of removable partial denture:** Many variables may contribute to unsuccessful utilizing of immediate partial dentures (removable bridges). The variables may include those problems related to failure of complete dentures, in addition to: (1) natural teeth to which partial dentures are anchored (called abutment teeth) may become tender, sore and/or mobile as support for the ridge changes during healing; (2) abutment teeth may decay or erode around the clasps or attachments; (3) tissues supporting the abutment teeth may fail after healing is complete.

3. **Breakage:** Due to the types of materials which are necessary in the construction of these appliances, breakage may occur even though the materials used were not defective. Factors which may contribute to breakage are: (1) chewing on foods or objects which are excessively hard; (2) gum tissue shrinkage which causes excessive pressures to be exerted unevenly on the dentures, especially as the tissues heal and change; (3) cracks which may be unnoticeable and which occurred previously from causes such as those mentioned in (1) and (2); (4) use of porcelain teeth as part of
the denture, or the dentures having been dropped or damaged previously in the event the dentures are relined. The above factors listed may also cause extensive denture tooth wear or chipping.

4. **Loose dentures:** Immediate complete dentures normally become less secure over the initial months as healing progresses and the ridge changes. Dentures themselves do not change unless subjected to extreme heat or dryness. After several months once healing is complete, the dentures will generally be quite loose and a reline or even rebase (replacement of all tissue colored material supporting the teeth) will become necessary. During the healing process some chairside relines may be performed, but eventually a laboratory processed reline or rebase will be necessary. It will be necessary to charge a fee for relining or rebasing dentures and I understand that the fee for immediate dentures does not cover this reline or rebase fee. Immediate partial dentures may become loose for the same reasons listed.

5. **Allergies to denture materials:** Infrequently, the oral tissues may exhibit allergic symptoms to the materials used in construction of either partial dentures or full dentures.

6. **Failure of supporting teeth and/or soft tissues:** Natural teeth supporting immediate partial dentures may fail due to decay; excessive trauma; gum tissue or bony tissue problems. This may necessitate extraction. The supporting soft tissues may fail due to many problems including poor dental or general health.

7. **Uncomfortable or strange feeling:** This may occur because of the differences between natural teeth and the artificial dentures. Most patients usually become accustomed to this feeling in time. However, some patients have great difficulty adapting to complete dentures.
8. **Esthetics or appearance:** Patients will be given the opportunity to observe the anticipated appearance of the dentures prior to processing. If satisfactory, this fact will be acknowledged by the patient=s signature (or signature of legal guardian) on the back of this for where indicated.

9. **It is the patient=s responsibility to seek attention when problems occur** and do not lessen in a reasonable amount of time; also, to be examined regularly to evaluate the tissue response to the dentures during healing, condition of the gums, and the patient=s oral health.

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of immediate dentures and have received answers to my satisfaction. I do voluntarily assume any and all possible problems and risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results relating to my ability to utilize artificial dentures successfully nor to their longevity. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I freely give my consent to allow and authorize Dr.__________________________ to render the dental treatment necessary or advisable to my dental condition(s), including administering and prescribing all anesthetics and/or medications.

Patient=s name (please print)  Signature of patient, legal guardian or authorized representative  Date

Witness to signature  Date
INFORMATIONAL INFORMED CONSENT

TEMPOROMANDIBULAR JOINT THERAPY (TMJ)

I UNDERSTAND that treatment of dental conditions pertaining to the TEMPOROMANDIBULAR JOINT includes certain risks and potential unsuccessful results. There exists the possibility that the TMJ problem may become worse through treatment. The treatment of TMJ problems is perhaps the most difficult procedure in dentistry in which to predict possible outcome. Even though great care and diligence will be exercised in this treatment, it is impossible to make any promises or guarantees for desired results nor can they be expected.

1. Depending upon the severity of the condition, treatment rendered may vary greatly. Discretion as to the method of treatment must be given to the treating dentist. There is no single right or wrong method of treatment. Engaging the help of a specialist or specialists may become necessary.

2. TMJ dysfunction is exhibited through many symptoms, such as: Pain and tightness in the jaw, head and neck; ringing and/or aching in the ears; headaches; clicking; restricted jaw movement; etc. Problems result from: dysfunction of jaw muscles and joints; traumatic injuries such as a blow to the jaw; teeth missing or misaligned; clenching or grinding of teeth; emotional stress; etc. Treatment may become simple such as leveling the bite through spot grinding of the teeth. This treatment could cause tooth sensitivity to develop which then may require additional dental procedures to be performed.

3. A comprehensive diagnostic evaluation, which may include intra-oral and extra-oral x-rays including cephalometric radiographs, tomographs, study models, periodontal probing, and clinical charting, is essential to aid in the mode of treatment which is to be followed.

4. Splints/bite planes may be necessary in order to attempt to accomplish a desired result. These are usually fabricated from plastic materials and are worn by the patient for various periods of time as prescribed by the treating dentist. The purpose of this type of appliance is to attempt to position the patient=s jaw into a comfortable
position. If and when such a position is able to be determined, a mode of treatment may then be pursued. This may include crowns, bridges, inlays, onlays, or other prostheses. It may be necessary to recommend orthodontic and/or surgical treatment. It is important to follow all instructions related to splint therapy and to be examined regularly. Unsupervised wearing of a splint may cause shifting of the teeth and a change in the bite which may be detrimental and may require extensive reconstruction to correct.

5. **Discomfort and/or pain may be experienced in various degrees** as the treatment progresses in the attempt to achieve a successful and satisfactory result. Pain or discomfort may range from oral muscle soreness to a numbness of the lips, jaw, tongue, teeth, and/or facial tissues, which numbness is usually temporary, but, rarely, may become permanent.
6. Engaging the assistance of a specialist may be necessary in diagnosis and/or treatment. In order to treat patients with TMJ problems as thoroughly as possible, it may be necessary to engage orthodontists, prosthodontists, periodontists, oral surgeons, endodontist, dentists limiting their practice to TMJ therapy, psychiatrists, psychologists, etc., in the attempt to achieve desired results. This may not become apparent until some time later in the course of the treatment. In most cases involving other professional help, this will necessitate additional expense during the course of treatment.

7. It is the patient=s responsibility to immediately seek attention should any undue or unexpected problems occur and to immediately notify this office if treatment cannot be continued in a timely manner or if any appointment cannot be attended. Absolute patient cooperation is necessary and mandatory during treatment.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose to Temporomandibular Joint (TMJ) treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this service have been explained to and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr._______________________________ and/or his/her associates to render any treatment necessary and/or advisable to my dental condition(s) including prescribing and administering any or all anesthetics and/or medications.

__________________________
Patient=s Name (please print) Signature of patient, legal guardian, or other authorized person Date

__________________________
Witness to signature Date
INFORMATIONAL INFORMED CONSENT

OCCLUSAL ADJUSTMENT AND SPLINT THERAPY

I UNDERSTAND that OCCLUSAL ADJUSTMENT and SPLINT THERAPY involves procedures to adjust the bite to enable the teeth to come together in the best configuration for that individual patient. I understand that occlusal adjustment and/or splint therapy includes risks and unsuccessful results that may possibly occur even though the utmost care and diligence is exercised in this dental procedure. I also understand that I have been given no promises or guarantees as to success or anticipated results. Possible risks and possible unsuccessful results which may occur are as follows:

1. **Grinding or smoothing of teeth:** Many times teeth to not occlude or articulate as they should because of the alignment of the biting surfaces and/or cusps of the teeth. In order to adjust the biting surfaces or cusps of the teeth it may become necessary to grind or disk these surfaces to make the occlusion (bite) better.

2. **Sensitivity of teeth:** As a result of the grinding or disking of the tooth biting surfaces or cusps, the teeth that are ground or disked may become somewhat sensitive. This sensitivity should gradually disappear in a relatively short period of time. However, in some cases where teeth are extremely sensitive or it is necessary to thin the enamel layer substantially, this sensitivity may persist for longer periods of time. If the sensitivity does not disappear, it is necessary to notify this office for an examination to determine whether or not further treatment is necessary.

3. **Necessity for crowns:** At times, if the occlusion (bite) is determined to be excessively out of balance, occlusal adjustment alone may not be accomplished merely by grinding or disking of the teeth because too much of the enamel surface would have to be removed which could lead to undesirable complications. In cases such as this, it may be necessary to crown the tooth or teeth to achieve a desirable articulation of teeth for a more level bite.

4. **Splinting of teeth:** The placement of splints involves fabrication and placement of appliances to achieve a positioning of the upper and lower jaws in conjunction with their musculature to attain a comfortable meshing or alignment of the upper and
lower teeth. Splints may also help to correct discrepancies in the bite which lead to a traumatic self-grinding or clenching of the teeth (uppers against lowers) which is called bruxism. Splints are often used in conjunction with occlusal adjustment procedures, particularly if the malocclusion (improper bite) is relatively severe.
5. **Splinting and splints may be irritating and uncomfortable:** Splints fit over the teeth and may be uncomfortable or irritating to the tongue and other oral tissues. However, unless the splints are worn diligently, there is little or no chance for successful results. After splinting and depending upon the final position the jaws assume to reach a comfortable position it may be necessary to do extensive treatment to bring the occlusion (biting position of teeth) into proper alignment. This might necessitate orthodontic treatment, crowns, and bridges, surgery, periodontal treatment, etc. In many cases, referral to a specialist may become necessary in the attempt to achieve the desired results. During treatment, splints must be worn diligently and in strict compliance with instructions received from the treating dentist.

6. **Breakage of splints:** Splints are constructed of plastic material and for this reason it is possible for the splints to break, no matter how well they are constructed. Should breakage occur, it is necessary to have the splint repaired and reinserted as soon as possible to prevent a relapse in the treatment process.

7. **Termination of Splint Therapy:** Splints must be monitored over the period of time that they are worn by the patient. If a patient continues to wear a splint without having the bite checked at regular intervals by the attending dentist, it is possible that the bite may change to the point that further intervention in the form of orthodontic therapy or extensive crown and bridgework may become necessary. Splint therapy should be terminated unless the patient is willing to see the dentist for regular follow-up examinations.

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of occlusal adjustment and splints and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial hard, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning the progression or results of the treatment. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr.______________________________ and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.
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 Oral or parenteral sedation is made available by this office to assist in minimizing anxiety that may be associated with going to the dentist. The intent of oral sedatives is to relax you yet still enable you to communicate with the dentist while treatment is being performed. Even though oral sedation is safe, effective and generally free of complications, by reading and signing this form, you acknowledge that you are aware of possible risks or oral sedation, acknowledge these risks, and consent to and accept the option of receiving oral sedation.

1. I acknowledge that I have read and signed this Informational Informed Consent form prior to my taking any form of oral sedation. I acknowledge that some oral sedatives are generally prescribed as sleeping pills but are safely used in conjunction with dental procedures to decrease anxiety.

2. I agree not to drive to or from the office after taking any sedative medication, and I understand that I am responsible for arranging for my own transportation to and from the dental office. I also agree not to drive or operate any machinery for the remainder of the day of treatment. I agree to have someone stay with me for several hours after sedation due to possible disorientation and to prevent possible injury from falling due to disorientation, loss of balance, etc.

3. I agree to inform the office and refrain from undergoing oral sedation if the following condition are present:
   A. Hypersensitivity to benzodiazepine drugs (Valium, Ativan, Versed)
   B. Pregnant or nursing.
   C. Liver or kidney disease.

4. I have disclosed to the dentist that I am taking any of the following drugs that may adversely react with oral sedatives: nefazodone (Serzone); cimetidine (tagamet, tagamet HB, Novocimetine, Peptol); levodopa (Dopar or Larodopa) for Parkinson=s Disease; antihistamines such as Benedryl or Tavist; verapamil (Calan); diltiazem (Cardizem);
Erythromycin and the azole antimycotic class of drugs (Biaxin, Nizoral or Sporanox); HIV treatment drugs (indinavir and nelfinovar); alcohol; any recreational/illicit drugs.

5. **Side effects** may include light-headedness, headache, dizziness, visual disturbances, amnesia, nausea, or allergic reactions. Rarely, these side effects may require medical attention or hospitalization. With some patients, especially smokers, oral sedatives do not provide that desired anti-anxiety effects; therefore, planned dental procedures may need to be postponed or terminated.

6. **Complications may ensue if instructions** of not eating or drinking for a specified interval prior to the dental appointment are not followed.
7. The onset of many oral sedatives is usually 15 to 30 minutes and the peak effect generally occurs between one and two hours. Effects of the drug are generally almost completely diminished after six to eight hours. In extreme cases, some patients sustain substantial or severe respiratory depression or the need for hospitalization and in very rare cases, possible cardiac reactions or death. Therefore, it is essential to notify the dentist immediately of any untoward reactions or delayed recovery following the procedure.

8. I consent to the use of nitrous oxide (laughing gas) in conjunction with oral sedation as well as local anesthetic.

9. I authorize the dentist to use his/her best judgment in managing unforeseen conditions which might unexpectedly arise during the course of oral sedation and the planned dental procedures. I acknowledge that lack of cooperation with recommendations made concerning dosage and other protocols associated with oral sedation may contribute to less than desired results.

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of oral or enteral sedation and have received answers to my satisfaction. I acknowledge that oral sedation is an option and not absolutely necessary for dental treatment, but, nevertheless, I accept this option. I do voluntarily assume any and all possible risks including, but not necessarily limited to those listed above, including risk of substantial harm or even death, which may be associated with oral sedative drugs. I acknowledge that planned treatment may be postponed or terminated or oral sedative drugs do not provide the desired effect, and I acknowledge that no guarantees or promises have been made to me concerning the efficacy of oral sedation in my case or the case of my minor child or ward for whom I give consent for this procedure. The fees for oral sedation have been explained to me and are satisfactory. By signing this document I am freely giving my consent to allow and authorize Dr._____________________________ and/or his/her associates or agents to render oral sedation as deemed appropriate and/or advisable to my dental condition, including prescribing and administering appropriate anesthetics and/or medications.

__________________________  ____________________________  ______________
Patient Name (please print)  Signature of patient, legal guardian  Date
or authorized representative

____________________________________
Witness to signature                      Date
INFORMATIONAL INFORMED CONSENT

PEDIATRIC (CHILDREN=S) DENTISTRY

I UNDERSTAND that in the dental treatment of CHILDREN, there are possible risks such as, but not limited to the following, including the understanding that no promises or guarantees of results have been made nor expected.

1. **Treating children often presents special problems:** perhaps the most difficult problem is that of controlling the child in order that no injury accidentally occurs as a result of the child making some abrupt or uncontrolled movements during treatment. In some cases it may be advisable to recommend medication to sedate the child prior to treatment. Additionally, various restraining devices may also be necessary to ensure safety of the child patient during treatment.

2. **Numbness:** There will be numbness in the tongue, lips, jaws, and/or facial tissues resulting from the administration of local anesthetic that may persist following treatment. During this period of numbness the child should be constantly monitored and reminded to not bite on or chew on the lips or the tongue. If the numbness appears to last longer then 24 hours the office should be notified at once.

3. **Caries susceptibility:** Because of the thinness of the enamel on deciduous (baby) teeth, a tendency for children to consume excessive sweets, difficulty in bruising and flossing regularly, etc., there can oftentimes occur large cavities very quickly in children=s teeth. Special care must be taken to avoid these problems. Preventive measures would include fluoride treatments, placing sealants, thorough brushing and flossing, control of diet, regular dental checkups.

4. **Fracture or breakage:** Due to the fragility of deciduous teeth it is oftentimes difficult to retain fillings, especially large fillings, in these teeth no matter how well the fillings have been placed. If the child has a difficult time retaining fillings or if the cavities are initially very large it may be advisable to place stainless steel crowns on the teeth in order to preserve them until they should be normally exfoliated.

5. **Pulpotomy:** Due to the thinness of the enamel, large pulp (nerve) chambers, and rapid spread of caries (decay) in deciduous teeth, the dentist may drill into the pulp chamber during decay removal. Upon such pulpal or nerve exposure, extraction may often be avoided by rendering a treatment in which the pulp tissue in the upper part of the tooth is removed and replaced with various filling materials and the tooth preserved to maintain space and chewing capability until the permanent tooth replaces the deciduous tooth. This procedure is called pulpotomy. At times, no matter how well done, these teeth may become infected and require extraction.
6. Abscesses: Deciduous teeth are particularly susceptible to a condition known as abscessing. Abscesses can occur if there has been deep invasion of caries into the tooth causing pulp tissue to become infected. The tooth usually becomes very sore and/or painful and swelling appears in the tissues near the root of the tooth. Abscesses may also occur from a traumatic injury to the tooth. The office should be contacted at once if this occurs. Pulpotomy as described above is generally not performed on an abscessed tooth and other alternatives must be considered.

7. Extraction and space maintenance: At times it is impossible to save a tooth. In such cases, the only alternative is to resort to extraction. Depending upon the necessity to maintain space for the eruption of permanent teeth it may be necessary to insert appliances known as space maintainers. These space maintainers may be either fixed or removable.

8. Responsibility: I acknowledge that it is my responsibility to immediately contact this office should any of the aforementioned or other adverse results occur following treatment. It is also my responsibility to set and keep appointments and follow instructions as given in order that proper dental health may be maintained for my child.

INFORMED CONSENT: I have been given the opportunity to ask any questions concerning the dental treatment of my child and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including but not limited to those addressed above, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr.______________________________ and/or his/her associates or agent to render any treatment, medications, anesthetics, etc. necessary and/or advisable to my child=s dental care.

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Witness to signature

Date
I UNDERSTAND that the treatment of teeth through the use of sealants is a preventive measure intended to facilitate the inhibition of dental caries (tooth decay) in the pits and fissures of the chewing (occlusal) surfaces of the teeth. Sealants are placed with the intent to prevent or delay conventional restorative measures used in restoring teeth with fillings or crowns after the onset of dental caries. I agree to assume any risks, if any, which may be associated with the placement of sealants even though care and diligence will be exercised by Dr.__________________________ in rendering this treatment. Thos risks include possible unsuccessful results and/or failure which are associated with, but not limited to the following:

1. **Preparation:** The teeth are prepared through use of an enamel etching technique. This etching is accomplished in one of two ways:
   a. Through using a special acid solution which merely etches the surface enamel in the area in which the sealant is to be placed to aid in its retention. The etching solution is somewhat caustic and if the patient makes any quick movements or interferes with the application of the etching agent there is a remote possibility of isolation or the working field being breached and a small amount of the solution finding its way onto limited areas of the soft tissues of the mouth which could cause some light tissue burns. This seldom occurs, but there is a remote possibility. If the etching solution contacts to the root surface the tooth may develop transient sensitivity.

   b. Through using a technique called **air abrasion**. Air abrasion also slightly etches the surface of the enamel in the area in which the sealant is to be placed to aid in the retention of the sealant. Air abrasion involves generation of a powdery dust which is sometimes accidentally inhaled and could cause some discomfort.

2. **De-bonding and/or dislodging:** There is the possibility of the sealant de-bonding or becoming dislodged over a period of time. This time is indeterminable because of many variables including, but not limited to the following:
   a. The forces of mastication (chewing). These forces differ from patient to patient. The forces may be much greater in one patient than in another. Also, the way the teeth occlude (come together in chewing) may have an effect on the life of the sealants.

   b. The types of food or other substances that are put in the mouth and chewed. Very sticky foods such as some types of gum; sticky candy such as caramels; some licorices; very hard substances, etc; may cause de-bonding or dislodging.
c. Inadequate oral hygiene such as infrequent or improper brushing of the teeth also may allow de-bonding with leakage around and under the sealant causing it to fail and allow decay to develop.

3. The entire tooth is not protected with sealants: Sealants are applied primarily to the pits and fissures that are in the chewing (occlusal) surfaces of the teeth. These pits and fissures are extremely susceptible to decay and can be protected through the application of sealants which flow into and seal those areas. However, sealants do not protect the areas between the teeth, so thorough brushing and the use of dental floss in these areas is necessary. Otherwise decay could develop in those areas uncovered by the sealants.
4. I understand that it is my responsibility to notify this office should any undue or unexpected problems occur or if any problems relating to the treatment rendered are experienced. Routine examinations by the dentist are recommended to allow ongoing assessment of the sealants placed.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of sealants and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of achieving the desired results from the treatment rendered. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving consent to authorize Dr._________________________ and/or all associates involved in rendering the services or treatment necessary to the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications.

__________________________________________________________

Patient=s Name (please print) Signature of patient, legal guardian, Date
or authorized representative

__________________________________________________________

Witness to signature Date
INFORMATIONAL INFORMED CONSENT

REMOVAL OF CROWNS AND BRIDGES

PURPOSE: There are three primary reasons to remove an individual crown or bridge that has been previously cemented to place:

1. Attempt to preserve and reclaim crowns and/or bridges that have fractured while in the mouth.
2. To render some type of necessary treatment to a tooth that is difficult or impossible to perform without removing the existing crown or bridge.
3. Confirm the presence of dental decay or other pathology that might be difficult to detect or obscured while the crown/bridgework is in place.

I UNDERSTAND that REMOVAL OF CROWNS AND BRIDGES includes possible inherent risks such as, but not limited to the following; and also understand that no promises or guarantees have been made or implied that the results of such treatment will be successful.

1. **Fracture or breakage:** Many crowns and bridges are fabricated either entirely in porcelain or with porcelain fused to an underlying metal structure. In the attempt to remove these types of crowns there is a distinct possibility that they might fracture (break) even though the attempt to remove them is done as carefully as possible.

2. **Fracture or breakage of tooth from which crown is removed:** Because of the leverage or torque pressures necessary in removing a crown from a tooth, there is a possibility of the fracturing or chipping of the tooth. At times these fractures are extensive enough to necessitate extracting the tooth.

3. **Trauma to the tooth:** Because of the pressure and/or torque necessary in some cases to remove a crown, these pressures or torque may result in the tooth being traumatized and the nerve (pulp) injured which may necessitate a root canal treatment in order to preserve the tooth. Instruments used to remove crowns and bridges may inadvertently lacerate the gums, other tissues within the mouth, and tongue.

4. **Failure of conventional methods in removing crowns:** There are certain methods and instruments which are utilized in conventional attempts to remove crowns from teeth. In some instances, none of these methods or instruments will effectively remove the crown. It may then become necessary in these instances to resort to removing the crown by cutting the crown from the tooth which will either severely damage or destroy the crown. This will require a new crown to be made.

5. **Inadvertent extraction of the crowned tooth:** In extremely rare cases, the amount of pressure or torque necessary to remove the crown from a tooth may result in the tooth being inadvertently extracted.

6. **As in other types of dental treatment:** It is the patient=s responsibility to seek attention should any undue circumstances occur postoperatively. The patient must diligently follow any preoperative and postoperative instructions given.
**INFORMED CONSENT:** I acknowledge that I have been given the opportunity to ask any questions regarding the nature and purpose of removing crowns and/or bridges and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning desired results of this procedure. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr.______________ and/or his/her associates to render any treatment advisable to my dental conditions including any and all anesthetics and/or medications.

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INFORMED REFUSAL: PERIODONTAL MAINTENANCE (D4910)

I, ______________________________, understand I have a serious periodontal condition (Periodontal Disease AAP _____) causing gum and bone infection and/or loss of bone, and I understand this can result in the ultimate loss of some or all my teeth. I hereby release from liability Dr. ____________________________, his/her hygienists, employees, and agents from any injury I may currently, or in the future, suffer as a result of my refusal to proceed with periodontal treatment or referral.

I understand that by NOT undertaking the recommended dental procedure called Periodontal Maintenance (D4910), it may have future adverse effects on my periodontal condition resulting in possible tooth loss.

I understand that it is recommended that I have this procedure, Periodontal Maintenance, performed in _______ monthly intervals on order to remover plaque (bacteria), calculus (tartar) and ineffective toxins (poisons) from the pocket areas that I can not reach with brushing and flossing.

I understand that an Adult Prophylaxis (D1110), typically called a routine cleaning®, will NOT address the removal of the plaque (bacteria), calculus (tartar) and ineffective toxins (poisons) to the base of the pockets in my tooth which range from _____mm to _____mm in depth (3mm or less is healthy).

I have carefully read the above and understand this refusal for treatment.

Patient signature_____________________________ Date ________________

Witness signature_____________________________ Date ________________
INFORMED REFUSAL: PERIODONTAL SCALING AND ROOT PLANING (D4341/D4342)

I,____________________________, am aware of the gum infection and periodontal disease present in my mouth. I hereby release from liability Dr. ______________________________, and his/her hygienists, employees and agents from any injury I may currently, or in the future, suffer as a result of my refusal to proceed with periodontal treatment or referral as recommended.

The recommended treatment plan, alternative treatments, and the benefits and risks involved have been fully explained to me to my satisfaction, and I have had all my questions answered. Inadequate or non-treatment may result in the progression of my gum infection and periodontal disease with the possible loss of gum tissue, bone, and teeth. My gum infection and periodontal disease may have adverse effects on my total body health. I fully understand these consequences and am willing to assume all of the risks involved.

I have carefully read the above and understand this refusal for treatment.

Patient signature_____________________________ Date_________________

Witness signature____________________________ Date_________________
INFORMATIONAL INFORMED CONSENT
COSMETIC TREATMENT
(INCLUDING BLEACHING, WHITENING, AND/OR VENEERS)

I UNDERSTAND that COSMETIC DENTAL treatment may entail certain risks and possible unsuccessful results, with even the possibility of failure to achieve the results which may be desired or expected. Even though care and diligence is exercised in this subject treatment, there are no guarantees of anticipated or desired results nor of the longevity of the treatment. Nevertheless, I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following:

1. **Reduction or roughening of tooth structure:** In making preparation of teeth for the reception of cosmetic veneers, either made of porcelain or composite resin, it may be necessary to reduce or roughen the surface of the tooth to which the veneer(s) may be bonded. This preparation will be done as conservatively as possible, but once this is done, the patient is committed to veneers or crowns for the duration of life. If the veneer covering breaks or comes off, the uncovered tooth may become susceptible to decay if the veneer is not replaced in a timely manner.

2. **Sensitivity of teeth:** As a result of applying whitening or bleaching materials or through the process of modifying teeth to accept veneers, there is the possibility of the development of tooth sensitivity which may last for days or months following application of the bleaching medium or following tooth preparation. In most cases, this sensitivity will alleviate over time but should such sensitivity persist for any length of time, the doctor must be apprised of this condition and fluoride treatments may be prescribed in certain cases to treat the persistent sensitivity.

3. **Chipping, breaking or loosening of the veneer** may occur any time following placement. Many factors may contribute to this happening such as: chewing of excessively hard material; changes in occlusal (biting) forces; traumatic blows to the mouth; failure of the bond between the veneer and tooth; and other such conditions over which the dentist has no control.

4. **Sensitivities or allergic reactions of soft tissue to whitening, bleaching, or bonding agents:** Even though this is an unusual occurrence, the gums or soft tissues of the mouth which may be exposed to the various agents used in these procedures may exhibit an allergic response. Also, gum tissues may show signs of inflammation. Should this occur, the doctor should be immediately made aware of this.

5. **Esthetics/Appearance:** Every attempt possible will be made to match and coordinate both the form and shade of veneers which will be placed to be cosmetically pleasing to the patient. However, there are some differences which may exist between that which is natural and that which is artificial making it impossible to have the shade and/or form perfectly match your natural dentition. Once veneers are bonded to place on the teeth, should any changes be desired later by the patient, a fee may be assessed to cover any extensive adjustments or remakes.

6. **Longevity:** It is impossible to place any specific time criteria on the length of time that veneers should last or for the lightened appearance of whitened or bleached teeth to remain at the lightened shades. These time periods may vary from a very short time to a very long time depending upon many conditions existing from patient to patient, which may be either internal, external or both.

7. **Bleaching Considerations:** Bleaching may either be done in-office or with take-home trays. The degree of whitening varies with the individual. The average patient may achieve considerable change (1-3 shades on the dental shade guide) but some patients take longer to achieve the desired level of whiteness of teeth. Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. Carbamide peroxide and other peroxide solutions used in bleaching are approved by the FDA as mouth antiseptics. Their use as intraoral bleaching agents has been effective but unknown risks may yet persist. Acceptance of bleaching treatment means acceptance of these yet unknown risks. Pregnant women are advised to consult with their physician before starting treatment.

8. **It is the patient’s responsibility to immediately inform the doctor and seek attention from him/her should any undue or unexpected problems occur or any dissatisfaction be present. Also, all instructions must be diligently followed, including scheduling and attending all appointments.**

INFORMED CONSENT TO TREATMENT: I have been given the opportunity to ask any and all questions regarding the nature and purpose of cosmetic dental treatment and have received all answers to my satisfaction. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this (these) services have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. and/or his/her associates to render any treatment deemed necessary, desirable and/or advisable to me, including the administration and/or prescribing of any anesthetics or medications.

Patient’s Name (please print) ___________________________ Signature of patient, legal guardian, or other authorized person ___________________________ Date _________________

Witness to Signature ___________________________ Date _________________
INFORMATIONAL INFORMED CONSENT

CONSENT FOR FINAL CEMENTATION

1. The nature and type of material used in my cosmetic veneers, for example, all porcelain, etc. has been explained to me and it is my understanding that the material to be used is:

By signing below I acknowledge and authorize the above listed material to be used in my mouth.

2. I have been given the opportunity to view my veneers as processed, either on models or in place in my mouth prior to final cementation. I approve the color, shape, feel and overall appearance of my veneers. I understand that once the veneers are placed in my mouth, the factors of color, shape, feel and overall appearance cannot be changed without additional and possibly significant time being taken and fees assessed. I further understand that removing cemented veneers may create the risk of injury or breakage to the underlying teeth and will destroy the veneer, requiring a remake.

By signing this Consent for Final Cementation I give Dr. ___________________________ my consent for final cementation and acknowledge my approval of the appearance and authorize use of the material cited above.

Patient’s Name (Please Print)  Signature or patient, legal guardian or authorized representative  Date
INFORMATIONAL INFORMED CONSENT
INFORMED CONSENT
ORAL SURGERY AND DENTAL EXTRACTIONS

I UNDERSTAND that ORAL SURGERY and/or DENTAL EXTRACTIONS include possible inherent risks such as, but not limited to the following:

1. **Injury to the nerves** of the lips, the tongue, the tissues in the floor of the mouth, and/or the cheeks, etc. These possible nerve injuries can cause numbness, tingling, burning, and loss of taste in the case of the tongue which may be of a temporary nature lasting a few days, a few weeks, a few months, or could possibly be permanent.

2. **Bleeding and/or bruising**: Bleeding could last for several hours. Should it persist, particularly being severe in nature, it should receive attention and this office must be contacted. Bruising may possibly be prolonged.

3. **Dry socket** occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful. Smoking, drinking liquids through a straw and not following post-operative recommendations can increase the chances of this complication.

4. **Sinus involvement**: In some cases, the root tips of upper teeth lie in close apposition to the tissues of the sinuses. During extraction or surgical procedures, the thin bone and tissues surrounding the sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically repaired.

5. **Infection**: No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, for infections to occur postoperatively. At times these may become serious. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon as possible should be received and this office must be contacted. In some cases hospitalization and/or treatment with I.V. antibiotics may become necessary.

6. **Fractured jaw, roots or bone fragments**: There is a possibility, even though extreme care is exercised, that the jawbone, teeth roots or bone spicules may be fractured which may require referral to a specialist for treatment. A decision may be made to leave a small piece of root or bone fragment in the jaw when its removal would require extensive surgery and/or risk of complications.

7. **Injury to adjacent teeth, fillings or porcelain crowns** may occur no matter how carefully surgical and/or extraction procedures are performed. Fractured fillings or crowns may require replacement.

8. **Bacterial endocarditis**: Because of the normal existence of bacteria in the oral cavity, the tissues of the heart in some cases and due to a number of conditions may be susceptible to bacterial infection transmitted from the mouth to the heart through the circulatory system. A condition called bacterial endocarditis (an infection of the heart) may occur which can result in damage to heart valves. If any heart problems are known or suspected (such as a heart murmur following rheumatic fever, existence of an artificial heart valve, cardiac damage following PhenFen use, etc.), the dentist must be informed prior to surgery.

9. **Muscle or jaw soreness** may be noticed following oral surgery and especially third molar extractions. Pre-existing conditions affecting the jaw joints (TMJ) may be aggravated by oral surgery. Clicking, popping, muscle soreness and difficulty opening may be noticed for some time following surgery. If such symptoms or conditions persist, the patient should call our office. The patient must notify the dentist of any such pre-existing conditions prior to surgery.

10. **Unusual reactions to medications given or prescribed**: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to instructions. Women on oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during the treatment period.

11. **Bisphosphonate Drug Risks**: For patients who have taken drugs such as Fosamax, Actamel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any oral surgical procedure involving bone, including extractions.

12. **It is my responsibility to contact the dentist and seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given me.**

**INFORMED CONSENT**: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option of seeking care with an oral and maxillofacial surgeon. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. ______________________ and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

__________________________  ___________________________  ___________________________
Patient's name (please print)  Signature of patient, legal guardian or authorized representative  Date

__________________________  ___________________________
Witness to signature  Date

(Rev. 08/06)
“Teeth whitening techniques” are designed to lighten dark or stained teeth. An oxygenated or peroxide type material is applied to the teeth and is accelerated by a high intensity light. While these materials appear to be safe, because their use is relatively new, unexpected problems can occur. Tooth sensitivity or tingling is the most common side effect. Soft tissue irritation can also occur. If a patient experiences these or other adverse symptoms after the procedure, he/she should call the office immediately.

Patients should also understand that the amount of bleaching and its duration might vary. While most teeth lighten to the extent desired, some are more resistant. In some instances lightening is minimal or unapparent, and additional bleaching over time may be required to maintain the lightening originally obtained.

I have read and understand the above description of possible consequences of in office whitening techniques. Being fully informed, I consent to and agree to the procedure.

Patient Signature: ___________________________ Date: ____________