Informed Consent

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949.496.7910 • Fax 949.496.3778

DENTIST
PATIENT

1. DRUGS, MEDICATIONS, X-RAYS AND EXAM

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. X-Rays are taken by qualified personnel. Exposure to X-Ray radiation (minimal). X-Ray pictures remain the property of this office. Full mouth series of X-Rays may be necessary to aid in diagnosing future dental treatment.

2. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examination but were found while working on the teeth. For example, root canal therapy may be discovered to be needed during routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

3. CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS

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 new crown, bridge. or cap (including the shape, fit. size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. There is always a chance that a Root Canal TX may be needed after crown preparation.

4. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the fir st 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.

5. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in 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 despite all effort to save it.

6. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy. crowns. and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph 113. 1 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, or fractured jaw. I understand removal of teeth can result in paraesthesia that can last permanently or for an indefinite period of time, and that paraesthesia numbness is a possible risk of injection/extraction. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

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 procedures may have a future adverse effect on my periodontal condition.

8. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are 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 more than 30 days, there will be additional charges.

9. DENTAL MATERIALS FACT SHEET ACKNOWLEDGMENT

SC Dental Care made the Dental Materials Fact Sheet available to me to read in the office and/or take home . I acknowledgement that this was made readily available for me and I have chosen to or not to read this material. I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that no other Dentist is responsible for my dental treatment.

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 dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligator. I understand that this practice provides space, equipment. support personnel and administrative services to allow,v each dentist to focus on patient care.

The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgement in the nature and manner of dental care and treatment provided. I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTISTS ARE NOT EMPLOYEE AGENTS OF THIS DENTAL MANAGEMENT COMPANY.

X ____DATE___________
SIGNATURE OF PATIENT

X ____DATE___________
PLEASE PRINT NAME. IF A MINOR. PLEASE PRINT THE MINORS NAME
If the patient is under the age of 18 years old. please have a parent or legal guardian sign this form.

x ____WITNESS ____________________
SIGNATURE OF DOCTOR

X ____DATE ___________
Signature ❑ Parent/Guardian ❑ Spouse

3. CROWNS, BRIDGES, & OTHER CASTINGS

DESCRIBE ____________ PAT INIT ________ MO/DAY/YR ____________

DESCRIBE ____________ PAT INIT ________ MO/DAY/YR ____________

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4. FILLINGS

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5. ENDODONTIC TREATMENT (ROOT CANAL)

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6. REMOVAL OF TEETH

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OTHER PROCEDURES

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