Presenter_____
Date_____

Robstown Dentistry

GENERAL DENTISTRY INFORMED CONSENT

PLEASE READ AND INITIAL THE ITEMS CHECKED BELOW. THEN READ & SIGN THE SECITON AT THE BOTTOM OF 2ND PAGE.

Patients Name: _____DOB_____

Check mark in block if applicable, Note N/A if not applicable.

- ❑ 1. **WORK TO BE DONE**
  I understand that I am having the following work done: Local Anesthetic_____ Nitrous Oxide_____ Fillings _____ Root Canals_____ Gum treatment_____ Extractions_____ Crowns_____ Bridges_____ Sealants_____
  (Initials _____)
- ❑ 2. **DRUGS AND MEDICATIONS**
  I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
  (Initials _____)
- ❑ 3. **EXAMINATIONS AND X-RAYS**
  I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.
  (Initials _____)
- ❑ 4. **CHANGES IN TREATMENT PLAN**
  I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr's Cooper, Garcia and Jackman, Munoz and staff to make any/all changes and additions as necessary.
  (Initials_____)
- ❑ 5. **TEMPOROMANDIBULAR JOINT DYSFUNCITON (TMD)**
  I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment and the cost of which is my responsibility.
  (Initials _____)
- ❑ 6. **FILLINGS and BUILD UP**
  I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling. Sensitivity is more common in white fillings than in silver fillings. I prefer **White_____,Silver_____ filling or No Preferance_____**
  (Initials _____)
- ❑ 7. **ENDODONTIC TREATMENT (ROOT CANAL)- PULPOTOMY (primary teeth)**
  I realize there is no guarantee that root canal treatment will save my tooth, and complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal (apicoectomy).
  (Initials _____)

- 8. **SEALANTS**

I understand that there is no guarantee how long a sealant will last. A sealant is a plastic material that is applied to the chewing surface of the back teeth-premolars and molars. It forms a barrier that protects teeth from plaque and acid attacks. It takes only a few minutes to seal each tooth. As long as the sealant remains intact, the tooth surface is protected from decay. Sealants hold up well under the force of normal chewing and usually last several years before a reapplication is needed.

(Initials_____)

- 9. **PERIODONTAL TREATMENT**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and /or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials _____)

- 10. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (Root Canal therapy, crowns, and periodontal surgery, etc.) and I authorize Dr's Cooper, Dr. Garcia, and Dr. Jackman, Dr. Munoz to remove the following teeth _____ And any others necessary for reasons in paragraph #4. I understand removing teeth does not always remove all the infections, if present. 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 teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalizations if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

- 11. **CROWN, BRIDGES AND CAPS , STAINLESS STEAL CROWNS(primary teeth)**

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 shape, fit, size and color) will be before cementation.

(Initials _____)

- 12. **DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize that final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my self or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

_____ _____

Signature of Patient, parent, Guardian or Personal Representative Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Relationship to patient