Consent for General Dentistry

CANNON FAMILY DENTISTRY

Patient Information

Patient First Name	MI	Patient Last Name	Patient Date of Birth

Informed Consent Information

- **Examination and X-Rays**
  I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.
- **Local Anesthesia**
  Anesthetizing agents are injected into a small area or injected as a nerve block directly into a larger area of the mouth with the intent of numbing the area to receive dental treatment. Risks include but are not limited to infection, swelling, allergic reactions, hematoma, bruising, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek/tongue/lip biting can occur from the injection. It is normal for the numbness to take time to wear off after treatment, usually 2-3 hours. However, it can take longer, and rarely the numbness is permanent if the nerve is injured.
- **Drugs, Medications & Sedation**
  I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and/or a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may increase risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.
- **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 my teeth that were not discovered during the examination. The most common being root canal therapy following routine restorative procedures. I give my permission to _____ to make any changes and additions as necessary.
- **Temporomandibular Joint Dysfunctions (TMJ)**
  I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joints of the lower jaw(near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well-tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.
- **Fillings**
  I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of newly placed fillings.
- **Removal of Teeth (Extraction)**
  I understand removing teeth does not always remove all 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 and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue(paraesthesia) that can last for an indefinite period of time or a fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. The cost of which is my responsibility.

- **Crowns, Bridges, Veneers, and Bonding**
  I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I 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 that the final opportunity to make changes to my new crown, bridge, or cap(including shape, fit, size, placement, and color) will be done before cementation after which additional fees may apply. It has been explained to me that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.
- **Dentures - Complete or Partial** I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including but not limited to looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be a "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement and the cost of relining is not included in the initial denture fee.
- **Endodontic Treatment (Root Canal)** I realize there is no guarantee that root canal treatment will save my tooth. I realize that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment(apicoectomy).
- **Periodontal Treatment** I understand periodontitis(gum disease) is a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, includingnon-surgical cleaning, gum surgery and/or extractions. I understand the success of treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations.

Consent

I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that no guarantees of results or absolute satisfaction are possible with dental treatment. I have truthfully answered all questions about my medical history and present health condition fully and truthfully. I have told _____ or other office personnel about all conditions, including allergies, which might indicate that I should receive oral medications and/or anti-anxiety agents. I will not hold _____ or associates responsible for any errors or omissions I may have made. I also understand if I ever have any changes in health status or in medication(s), I need to inform the doctor at the next appointment. I authorize _____to forward a review of findings and/or any other necessary dental information to the referring doctor for his/her records, as well as any third parties such as insurance companies who may request information. I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All of my questions have been answered by _____ in a satisfactory manner and I believe I have all of the necessary information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

Patient's Signature	Date	Doctor's Signature	Date