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GENERAL DENTAL STANDARD CONSENT

1. **EXAMINATION AND X-RAYS**

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. **TREATMENT PLAN**

I understand that I may be having the following work done but not limited to: Fillings, Periodontal treatment, Crowns/Inlays/Onlays, Extractions, Root Canals, Dentures, X-rays, Surgery, Implants and or
Other_____.

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 the examination. For example, root canal therapy following routine restorative procedures. I give permission to Dr. Kezian and Associates to make any changes and additions necessary.

4. **DIAGNOSIS**

I understand that diagnostic procedures can involve several appointments/ multiple radiographic images and in complex cases an additional specialist examination may be required to develop a comprehensive treatment plan.

5. **DRUGS AND MEDICATIONS**

I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and 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 me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

6. **LOCAL ANESTHESIA**

I understand that local anesthesia is recommended for the most of the procedures performed and its benefits far outweigh the potential risks, however I am aware that it can result in allergic reaction and life threatening anaphylactic shock. Furthermore, it can result in permanent damage to the nerve, a partial or complete permanent numbness lasting several days to months, bruising or formation of hematoma.

7. **PREVENTATIVE TREATMENT**

I understand that my dentist may recommend alternative approaches for optimization of my dental/ overall health, including but not limited to nutritional counseling/ tobacco counseling/ oral hygiene instructions/ fluoride treatment.

8. **WHITENING TREATMENT**

There may be sensitivity associated with the whitening procedures done in the office and at home (trays). It is common consequence of whitening. Patient is advised to take analgesics and treat the area with topical fluoride until sensitivity subsides.

9. **PERIODONTAL CLEANING/ SCALING AND ROOT PLANING**

I understand that the most common complications are pain, bleeding, tissue (gum) laceration, sensitivity to temperature or foods, swelling, ulceration (infection), tooth fracture, breaking of fillings, dislodging of crowns or veneers. Reaction to fluoride treatment may cause nausea or vomiting.

10. **PERIODONTAL LOSS (TISSUE AND BONE)**

I understand that I may have a serious condition, causing gum inflammation, bone loss, and it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, bone grafts, extractions, laser treatment and bacterial irrigation. Any dental procedures may have future adverse effects on my periodontal condition. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

11. **RESTORATIVE TREATMENT**

I understand that the most common complications are pain, sensitivity to temperature, fracture of a tooth, nerve damage, damage to other teeth, occlusal (bite) discrepancies, TMJ complications, reactions to drugs/anesthesia. I understand that sometimes existing caries may cause inflammation of the nerve and subsequently filling restorations may have to be further treated by a root canal therapy due to the initial underlined inflammation of the nerve. Also I understand that once the tooth is restored with a filling material it is never going to feel the same as natural teeth.

12. **BONDINGS/ FILLINGS**

I understand that care must be exercised in chewing on the filling(s) during the first 24 hours to avoid breakage. I understand that sensitivity is a common after-effect of a newly placed filling.

13. **REMOVAL OF TEETH**

Alternative 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. 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, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time or fractured jaw. I understand 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.

14. **CROWNS/ INLAYS/ ONLAYS/ BRIDGES/ VENEERS**

I understand that sometimes it is not possible to match the color of the artificial teeth exactly to the natural teeth. Most of the time my dentist will give me an option of having the shade taken in the laboratory under the different light sources. I further understand that I may be wearing temporary crowns/ fillings that may come off easily and I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize that the final opportunity to make changes to my restoration (including shape, size, fit and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from the preparation date. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be an additional charge for remakes due to me delaying permanent cementation. I also understand that I may require root canal therapy after routine crown/ inlay/ onlay/ bridge preparation. It will be determined by my health care provider at the time of presenting symptoms if further treatment with root canal therapy is required.

15. **ENDODONTIC TREATMENT (ROOT CANAL THERAPY)**

I understand that there is no guarantee that root canal treatment will save my tooth, and the complications can occur from the treatment. Occasionally root canal filling materials may extend through the tooth, which does not necessarily affect the success of treatment. I understand the endodontic files and reamers are very fine instruments; stresses vented in their manufacture can cause them to separate or break during use. I understand that sometimes additional surgical procedures or re-treatment may be necessary following root canal treatment I understand that the tooth may be lost in spire of all the efforts to save it. Root canal treated teeth must be covered by crowns or bridges and if I do not follow the post-operative instructions, it could lead to a fracture and failure of root canal treated tooth. I understand that occasionally additional surgical procedures may be necessary following root canal treatments (apicoectomy).

16. **DENTURES AND PARTIALS**

I understand that wearing dentures or partials may be difficult. Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placed right after surgery/ extractions) may be painful and may require considerable adjustments and several relines. Regular follow up is necessary to maintain soft tissue health and optimized healing. A permanent reline will be needed later. This is not included in the denture fee. I understand that this is my responsibility to return for delivery of dentures and follow up appointments. I understand that failure to keep my appointment may result in poor fitting dentures or partials. If a remake is required due to my delay of more than 30 days, there will be an additional charge.

17. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the car) subsequent to routine dental treatment wherein the mouth is held in the open position. However, 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.

18. **ORTHODONTICS**

Our doctors are experienced/ trained in the provision of Invisalign orthodontic treatment. It is the patient's responsibility to be 100% compliant with instructions and homecare for the treatment to be successful. I understand that additional fees maybe applied if refinement of the treatment is needed. The costs of the retainers are not included in the initial Invisalign treatment fee.

AKNOWLEDGEMENT

I certify that the answers to the health questionnaire are accurate and correct to the best of my knowledge. Since a change of medical conditions, pregnancy or medications can affect dental treatment; I understand the importance and agree to notify Dr. Kezian and Associates of any changes at any subsequent appointment

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested an authorized.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

☐ **I give my consent for the proposed treatment as described above**

☐ **I refuse to give my consent for the proposed treatment as described above.**
I have been informed of the potential consequences of my decision to refuse treatment.

_____	_____
Patients Signature	**Date**
_____	_____
Dentists Signature	**Date**
_____	_____
Witness Signature	**Date**