Informed Consent Form for General Dental Procedures

Patient Name: **Date:**

Our patients have the right to accept or refuse the recommended dental treatment proposed by their dentist. Your dentist and dental team will thoroughly communicate with you the ideal and alternative treatment options, the risks associated with both, and the risk of no treatment, before you are asked to give consent.

Do not consent to treatment unless you are satisfied with the answers conveyed to you by your dental team and all of your questions have been answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is also important that you follow your dentist's advice and recommendations regarding medications, pre- and post-treatment instructions, referrals to specialists, and the necessity to return for scheduled appointments. Failure to follow the advice and recommendations of your dentist may result in a poor treatment outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you have a serious heart condition, or are taking blood thinners or anticoagulants, advise your dentist immediately so he/she can consult with your physician.

In dentistry, there are commonly known risks and potential complications associated with dental treatment. No provider can guarantee the success of the recommended treatment, or that you will not experience a complication or less than an optimal result. Although these complications are rare, they can and do occur occasionally.

Medications and 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. They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that 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 in the manner prescribed may increase the likelihood of continued or aggravated infection or pain, as well as the potential resistance towards future treatment of my condition. **Women:** I understand that antibiotics can decrease the effectiveness of birth control and I have been informed of this risk.

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 teeth that were not discovered during the initial examination (ie. root canal therapy following routine restorative procedures). My dentist will discuss any modifications to the original treatment plan with me prior to completing treatment.

Temporomandibular Joint (TMJ) Dysfunction: I understand that symptoms of popping, clicking, locking, and pain, can intensify or develop in the joint of the lower jaw (near the ear) following routine dental treatment caused by the mouth being open for prolonged period of time. However, the symptoms of TMJ dysfunction 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.

Fillings: I understand that care must be exercised in chewing on recently restored teeth during the first 24 hours to prevent breakage of the filling. I have been informed that sensitivity is a common after-effect of a newly placed filling. The restorative material I have chosen to have is:

I understand that dentistry is not an exact science and therefore comprehend that results cannot be guaranteed. I acknowledge that no guarantee or assurance had been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each dentist is an individual practitioner and is individually responsible for

the dental care rendered to me. I also understand that no other dentist other than my treating dentist is responsible for my dental treatment.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of the recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment. This form will remain in effect until terminated by either this dental office or by you.

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Patient Name (Print) Date of Birth

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Patient Signature Date

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Witness Date