Patient's Name: _____

PATIENT CONSENT TO TREATMENT

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

(Initials) _____

[ ] 1. DENTAL EXAMINATION AND TREATMENT PLAN

California Law requires that the dentist examine and diagnose all new patients **prior to delegating general supervision duties to auxiliaries including hygienist for cleaning.** Proper diagnosis requires full mouth dental x-rays.

(Initials) _____

[ ] 2. 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 examination. For example, root canal therapy may follow routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary, **after explaining the reason and obtaining my consent.**

(Initials)_____

[ ] 3. DRUGS, MEDICATIONS, AND ANESTHESIA

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage and cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medication and/or drugs, or until fully recovered from their effects (this includes a period of at lest twenty-four (24) hours after my release from surgery)

I understand occasionally upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chlorylhydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

(Initials)_____

[ ] 4. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long-term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

(Initials)_____

PERIODONTICS- I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to the loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

(Initials) _____

[ ] 5. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised that if this condition persists without treatment or surgery, my present condition will probably worsen in time.

Potential risks include but are not limited to:

A. Post-operative discomfort, swelling, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage (possibly exposing crown margins) tooth looseness, delayed healing (dry socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery)

B. Injury to adjacent teeth, caps or fillings (requiring the recementation of crowns, replacement of fillings, fabrications of crowns, or extraction), or injury to other tissues not within the described surgical area.

C. Limitation of opening, stiffness of facial and/or neck muscles, change in bite, or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).

D. Residual root fragments or bone spicules left when completed removal would require extensive surgery or needless surgical complications

E. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery. Possible bone fracture, which may require wiring or surgical treatment.

F. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side, this may persist for several weeks, months, or, in remote instances, permanently.

(Initials) _____

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as to complete the planned operation.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment on for procedures in addition to or different from those now contemplated, I request and authorize to do whatever (s) he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(Initials) _____

[ ] 6. FILLINGS:

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure, lost or decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains or existing tooth structures off, I may need to receive more extensive treatment (such as root canal therapy, post and build up, and

[ ] 7. ENDODONTIC TREATMENT (ROOT CANAL THERAPY):

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

I understand that treatment risks can include, but are not limited to:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.

B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.

C. Infection

D. Restricted jaw opening.

E. Breakage of root canal instruments during treatment, which may in the judgment of the doctor, be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.

F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.

G. Risk of temporary or permanent numbness in treatment area.

Either of which may persist for several days or longer.

If an "open and medicate" or pulpotomy procedure is performed. I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

(Initials) _____

[ ] 8. CROWNS AND BRIDGE (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth, I understand that at times, during the preparation of tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy. I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restorations, leading to further dental treatment.

(Initials) _____

[ ] 9. DENTURES-COMPLETE OR PARTIAL:

The problems of wearing dentures have been explained to me including looseness, soreness, and possible breakage, and reline due to tissue change. Follow- up appointments are an integral part of maintenance and success of prosthetic appliance. The doctor should immediately examine persistent sore spots.

I further understand that surgical intervention (i.e. tore bone removal, bone recountouring, or implant(s) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

(Initials) _____

[ ] 10. PEDODONTICS (CHILD DENTISTRY):

I understand that the following procedures are routinely used at Personal Dental Office, as well as being accepted procedures in the dental profession.

A. POSITIVE REINFORCEMENT- Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and token objects or toys.

B. VOICE CONTROL- The attention of a disruptive child is gained by changing the tone of voice or increasing the volume of the doctor's voice.

C. PHYSICAL RESTRAINT- Restraining the child's disruptive movements by holding down their hands, upper body, head and/or legs by the use of the dentists' or assistants hand or arm, or by the use of a special device (referred to as a "papoose board").

D. NITROUS OXIDE AND/OR ORAL SEDATION- Nitrous Oxide is a mild gas that is mixed with oxygen, and it is used to administer to children to help them relax. With their use the parent/ or guardian must understand that the child should not eat or drink for a period to the sedation appointment. The parent/ or guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/ or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation and the possibility of then needing an extraction. (Initials) _____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION, I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE, I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT PERSONAL DENTAL OFFICE PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF IT'S PATIENTS.

Signature: _____ Relationship: _____ Date: _____

Patient or Legal Representative