Peninsula Family Dental Center

DENTAL TREATMENT CONSENT FORM

1. WORK TO BE DONE

I understand that I am to have work done as detailed in the attached plan.

Initials_____

2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching and vomiting, and/or anaphylactic (severe allergic reaction). I have informed the dentist of any known allergies to medication.

Initials_____

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedure because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give permission to the Dentist to make any/all changes and additions as necessary; as long as I am informed.

Initials_____

4. REMOVAL OF TEETH

Alternatives 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 for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, selling, spread of infections, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise, the cost of which is my responsibility.

Initials_____

5. CROWNS AND VENEERS

a. Treatment involves covering the tooth above the gum line with a crown (cap) or covering the front surface of the tooth with tooth colored bonded porcelain laminate called a veneer. 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 come off easily and that I must be careful to ensure that they are kept on until the permanent crown(s) are delivered. I realize the final opportunity to make changes in my new crown, bridge or veneer (including shape, fit, size and color) will be before cementation(s).

It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, veneer. I understand there will be additional charges for remakes or other treatment due to my delaying of permanent cementation. Please note it is the patient responsibility to notify dentist of any none metal allergies.

Initials_____

b. I am electing to have a porcelain (tooth colored) crown instead of a full metal crown (silver or gold). I understand that my insurance may not pay for porcelain crowns on back teeth or they may pay at a lower metal rate

Initials_____

c. I am electing to do a fixed bridge replacement of missing teeth instead of a removal appliance. I understand that this fixed bridgework may not be a covered benefit under my insurance policy.

Initials_____

6. FILLINGS

I understand a more extensive restoration than originally diagnosed may be required due to additional decay found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown or both. I understand that sensitivity is a common after-effect of a newly placed filling. I realize that fillings are rarely "permanent" and usually require periodic replacement.

_____ Tooth number and surfaces_____

An amalgam restoration requires the Dentist to remove a larger amount of tooth structure when preparing the tooth for restoration. amalgam fillings are dark in color. In contrast, the composite (resin) restoration bonds to the tooth and can actually strengthen tooth structure. It also matches the color of the tooth and is virtually undetectable to the untrained eye. Because it is more technique sensitive, placement of a composite filling may take longer and is more expensive. **Insurance patients please note: your insurance company may not pay for a composite restoration at all or it may reduce your benefit to that of an amalgam filling, especially when the restoration is on a posterior (back) tooth; meaning the insurance may pay at a lower amalgam rate, so patient copays will be a little higher.** Please carefully review out consent form and discuss any questions the Dentist.

Initials_____

7. ENDODONTIC TRATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth. The tooth may be sensitive during treatment and even remain tender for some time after treatment. Some complications such as hard to detect root fractures is one of the reasons why root canals fail. Since teeth with root canals are more brittle that other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that occasionally additional surgical procedures may be necessary follow root canal therapy (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Initials_____

8. DENTURES, COMPLETE OR PARTIAL

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent". Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more permanent relines within several months.

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or resin based. The problem of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the 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 I will need multiple appointments for adjustments. A permanent reline or a second set of dentures will be necessary later. This is NOT included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charge.

Initials_____

9. SCALING AND ROOT PLANNING (SRP)

I understand that periodontal disease involves the soft tissue surrounding the teeth (gum tissue). The causes of this disease are complex and may include genetic factors, hard and soft deposits on the teeth (plaque or calculus), and various bacteria and their toxins. Symptoms include bleeding gums, swelling, infection, bad breath, tooth and root sensitivity, gum recession, loosened teeth, and possible loss of teeth. Scaling and Root Planning (SRP) includes the removal of all debris and bacterial plaque, and monitoring of home care to maintain tissue health.

Treatment risks: This treatment may result in unintended consequences, including, but not limited to bleeding; infection; tissue swelling or bruising; increased sensitivity to hot, cold, or sweets; esthetic changes; exposure of crown margins; exposed root surfaces due to recession of gum line; pain in the associated teeth, including roots; temporary or permanent numbness; and tooth mobility or loss.

Recall (Check One):

After scaling and root planning, I will be placed on a _____ three month recall, _____ four month recall, _____, or _____ six month recall to monitor my home care. I understand that by failing to comply with the

recommended recall that my periodontal condition may worsen and I may lose teeth. I also understand that I may have to do scaling and root planning sooner than insurance benefit will allow, due to not following the recommended recall.

I have discussed treatment alternatives, risks, outcomes, and costs with my dentist and all of my questions have been answered before making a decision. I understand that dentistry is not an exact science and that there is no guaranteed results; and that even with this treatment tooth loss may still occur.

10. NITROUS OXIDE

I elect to have nitrous oxide (laughing gas) in conjunction with my dental treatment. I have been informed and understand possible side effects that might occur.

Initials_____

11. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I elect to follow the doctors' recommendations of optimal dental treatment, including all comprehensive procedures. I understand that the dentist doesn't not base treatment on what is or isn't covered, it is what he as the doctor recommends.

Initials_____

12. RELEASE FROM LIABILITY AGAINST DOCTOR'S ADVISE

Being a lawful age, I hereby release Dr. _____ of Peninsula Family Dental Center, its employees and agents from all liability for any injury I currently, or may have in the future, suffer as a result of my refusal to have the following service(s) or consultations(s) performed:

_____Exam

_____Radiographs

_____Referral/treatment for periodontal condition

_____Other _____

I have thoroughly discussed the need for service (s) or consultation (s) with the Dentist. All of my questions have been answered and I fully understand why the recommendations have been made and the consequences of my refusal to have them performed. I also understand that in the event of an emergency, i.e. pain, swelling, the office will do its best to accommodate me, and I will be charged a fee for a limited emergency exam and x-ray in addition to the cost of treatment each time this occurs.

_____ _____

Signature of Patient/Parent/Guardian Date