General Dentistry Informed Consent

Patient's Name ____ DOB : ____________

1. **WORK TO BE DONE**

I understand that I am having the following work done: [ ] filling [ ] bridges [ ] crowns [ ] extractions [ ] impacted teeth removed [ ] root canals [ ] dentures [ ] exam [x] x-rays [ ] prophy [ ] others (initials _______) (initials _______) (initials _______)

2. **DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting and or anaphylactic shock. (initials _________)

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 examination, for example root canal therapy following routine restorative procedures. I give my permission to the dentist to make any / all changes and additions as necessary. (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 have the following teeth removed_________ and any others necessary for reason in paragraph # 3. I understand removing teeth does not always remove all infections if present and it may be necessary to have further treatment by a specialist if complications arise during or after treatment, the cost of which is my responsibility (initials ________)

5. **CROWNS, BRIDGES AND VENEERS**

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 the final opportunity to make changes in my new crown, bridge or veneer (including shape, size, fit and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may cause for remakes due to my delayed permanent cementation
(initials_________) (initials_________) (initials_________) (initials_________)

6. **ENDODONTIC TREAMENT (ROOT CANAL)**

I realize that there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost, despite all efforts to save it. (initials_________) (initials_________)

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

I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and or extractions. I understand that under taking any dental procedures may have a future adverse effect on my periodontal condition. (initials_________) (initials_________)

8. **FILLINGS**

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (initials_________) (initials_________) (initials_________)

9. **DENTURES**

I understand the wearing of dentures is difficult, sore spots, and altered speech and difficulty in eating are common problems. Immediate denture (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. I understand a remake is required due to my delays of more than 30 days and there will be additional charges.
(initials__________) (initials_________)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care given to me. I here by authorize any of the doctors or auxiliaries of Yong & Kim Dentistry to proceed with and perform the dental restorations and treatment as explained to me. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court cost that may be incurred to satisfy this obligation. Should any dispute arise over dental services provided to me, that is whether any dental service is rendered as allegedly unnecessary, unauthorized or was improperly negligently, or incompetently performed, said dispute will be submitted to Peer review by the local Component of the American Dental Association. The decision of Peer review shall be binding on both parties. I have read, understood, and agree to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this assignment.

Patient Signature: ____ Date________________

Doctor: ____ Witness:_________________________