GENERAL DENTISTRY INFORMED CONSENT

Dentist DR. MASTERS **Patient** _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings ( ), Crowns ( ), Extractions ( ), Impacted teeth removed ( ), Root Canals ( ), X-rays ( ), Dentures ( ), Other EXAM AND CLEANING X (Initials_____)

2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and /or anaphylactic shock. X (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. X (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 reason in paragraph #3. 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, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

5. CROWNS, BRIDGES AND CAPS

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 cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. (Initials_____)

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize 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 tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. (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 undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

8. FILLINGS

I understand that care must be exercised in chewing on fillings, espcially 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_____)

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture 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. If a remake is required due to my delays of more than 30 days, there will be additional charges. (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 I have requested and authorized. I understand that no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors of dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. 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 costs that may be incurred to satisfy this obligation.

Signature of Patient _____ Date _____

Signature of Doctor DR. MASTERS Date _____

INFORMED CONSENT AGREEMENT FOR GENERAL TREATMENT

1. I have been presented with a treatment plan. I have been informed of other methods of treatment and the alternatives. The expected results and risks of the proposed treatment including the use of anesthesia (and no treatment) have been explained to me.

2. I authorize Dr. MASTERS to dispose of any tissues, which in the course of treatment may be removed.

3. I understand that there is no guarantee of success or permanence of the treatment.

4. Dr. MASTERS is authorized to use any and all records, radiographs, photographs, and diagnostic casts which may be pertinent to the case for educational or publication purposes. All such records become the property of Dr. MASTERS.

5. I understand that dental conditions in my mouth can change and alter the proposed treatment plan.

6. I have been presented with the estimated costs of my treatment. I understand that they are subject to change with changes in the treatment plan.

7. I have read and agree to the foregoing. I have had the opportunity to ask treatment-related questions. All my questions have been answered by the doctor, and I fully understand the statements in this consent form. My signature below constitutes my agreement:

_____ Patient's signature
(legal guardian if minor)
_____ Date