## Informed Consent

## Wildomar Dental Care

**Patient (Parent)'s Name**________________________________________________________________

1. **Work to be done**: I understand that I am having the following work done: Filling__, extraction___, periodontal___, crowns and bridges____, dentures___, root canal therapy___, other___

2. **Change in treatment plan**: I understand that during treatment it may be necessary to change procedures because of conditions found while working on teeth that were not found during examination. I give the dentist consent to make those changes as necessary

Initial_______

3. **Drugs and medications**: I understand that antibiotics and analgesics and other medication can cause allergic reactions such as redness and swelling of tissue, pain, itching, vomiting, and anaphylactic shock.

Initial_____

4. **Fillings**: I understand that care must be exercised in fillings especially during the first 24 hours to avoid breakage; I understand that a more extensive filling, other than originally diagnosed, may be required due to additional decay. I understand that significant sensitivity is a common effect of a newly placed filling.

Initial_______

5. **Removal of teeth**: I authorize the dentist to remove the following teeth ________, and any necessary under paragraph 2. I understand that removal of teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I also understand the risks involved in having teeth removed, some of which are: pain, swelling, spreading of the infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fracture the jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during the following treatment.

Initial_______

6. **Periodontal Loss (tissue and bone):** I understand that I have a serious condition, causing gum inflammation or bone loss that can lead to the loss of my teeth. The alternative treatments have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse affect on my periodontal condition.

Initial_______

7. **Endodontics Treatment (root canal therapy):** 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 effect the success of the treatment. I understand that endodontics 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 the root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save. I also understand that the endodontics treated tooth is fragile and needs a crown for protection.

Initial_______

8. **Crowns, Bridges, and bonding Veneer**: I understand that sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, bridges, or veneers, which may come off easily and that I must be careful to ensure that they are kept on until the permanent ones are delivered. I understand that after the tooth preparation appointment, I must come back to the office within one month for the permanent crown, bridge, or veneer to be permanently cemented on. I understand that if I do not show for the appointment, I am financially responsible for the fee of the new crown, bridge, or veneer.

Initial_______

9. **Denture (Partial or Complete):** I understand that full or partial dentures are artificial, and the problems of wearing these appliances have been explained to me including, looseness, soreness, and possible breakage. Immediate denture (replacement of denture immediately after extractions) may be painful and required 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 denture 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 to my cost for laboratory fees.

Initial_______

I understand that dentistry is not an exact science; 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 hereby authorize anyone of the dentist and dental auxiliaries to perform the dental treatment as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen and un-diagnosable 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 co-payments. I agree to pay any attorney's fees, collection fee, or court costs that may be incurred to satisfy this obligation.

Signature of Patient(or Parent)____________________________________________ Date:____________________

Signature of treating Doctor:____________________________________________ Witness_____________________