Date

Patient's Name

GENERAL DENTISTRY INFORMED CONSENT

MISSION DENTAL ARTS

1. **WORK TO BE DONE**
I understand that I am having the following work done: Fillings _____, Bridges _____, Crowns _____, Extractions _____. Impacted teeth removed, _____Root Canals, _____Dentures, _____Other _____. (Initials _____)

2. **DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, 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 remove the following teeth _____and any others for reasons in paragraph #3. I understand removing teeth does not always remove 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 that final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. 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 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 _____)

7. **HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS)**
Hygiene - 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 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 a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction. (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 _____)

9. **DENTURES**
I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extraction) 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 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 each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

I hereby authorize Missions Dental Arts and his 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 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 these obligation.

I have the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Should any dispute arise over dental services provided to me , that is whether any dental service rendered was allegedly unnecessary, unauthorized or was improperly, negligently, or incompletely 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 agreed to the above.

1. Patient's signature _____ Date _____

2. Parent's signature (if patient is under 18 yrs) _____ Date _____