Patient Name:**____**

General Dentistry Patient Acknowledgement

Treatment Plan

I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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.

Drug and Medications

I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock. I understand that the administration of local anesthetic may cause an untoward reaction or side effect, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

Extractions

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.

Crowns, Bridges, 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 come off easily and that I must be careful to insure that they are kept on until the permanent restoration is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. Excessive delay in the permanent cementation of crowns or bridges may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Patient Name____

Endodontic Therapy

I realize there is no guarantee that root canal treatment will save a 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 and defects 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 restore it.

Periodontal Disease

I understand that if I have been diagnosed with a condition causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. I understand that periodontal surgery is intended to strengthen the bone support of teeth or improve the health of the gum tissue. Success of periodontal surgery requires my strict maintenance of oral home care and compliance with the recommendations of the dentist and dental staff.

Fillings

I understand that care must be exercised in chewing on filling teeth, especially during the first few hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decay. I understand that significant sensitivity sometimes occurs following a newly placed restoration.

Partials and Dentures

I understand the wearing of partials/dentures is difficult in the beginning: sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful at first and may require considerable adjusting and several relines. A permanent reline will be needed at a later date. I understand that it is my responsibility to return for delivery of my partial/denture and that failure to keep my delivery appointment my result in poorly fitted dentures. If a remake is required due to my delay an additional charge could be incurred.

Patient Name_______________________________

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT AND CONSENT TO PROCEED

I certify that the answers to my health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I understand that dentistry is not an exact science and therefore, practitioners cannot 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 have received information about the proposed treatment. I have discussed my treatment with *The Ford Clinic* and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment.

I authorize *The Ford Clinic* or assistants as may be designated to perform those procedures as deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for whom I have responsibility, including arrangement and/or administration of any analgesic, therapeutic, and/or other pharmaceutical agent(s) related to restorative, palliative, therapeutic or surgical treatments.

I wish to proceed with the recommended treatment.

Signed:_________________________________/________________________________
(printed name)

Date:_____________________

Parent or
Guardian:______________________________/__________________________________
(printed name)

Date:_____________________