THE SZIKMAN DENTAL GROUP, P.C. GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME ____

*** PLEASE NOTE:** This is an all-purpose consent form. Actual procedures will be treatment planned and discussed with each patient accordingly.

1. TREATMENT TO BE PERFORMED
I understand that I will be receiving an examination that includes a sufficient number of dental X-rays that may be necessary to complete my examination and any additional community-appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if my dentist deems the need for a referral to a specialist necessary, then any costs of this referral that are not covered by dental insurance would be my responsibility. (Initials__________)

2. DRUGS AND MEDICATIONS
I understand that antibiotics, analgesics and other medications can cause allergic reactions manifesting clinical symptoms such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (a severe allergic reaction). I understand that it is my responsibility to inform my dentist of any allergies to specific medications to avoid possible adverse effects from medication that my dentist will prescribe.
(Initials__________)

LOCAL ANESTHETICS
The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in the heart rate; however, it will return to normal shortly thereafter. Common complications that can occur from local anesthetic (but are not limited to) are pain, swelling and bruising. Rare serious complications may occur that can include (but are not limited to) permanent numbness, abnormal sensation, transient blindness, and even death.
(Initials__________)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary once I have been informed of these changes and have consented to them. I also understand that by not following my dentist's recommendation, delayed treatment can lead to but not limited to more discomfort, increase the complexity of the treatment outcome, or eventual loss of teeth. (Initials__________)

4. EXTRACTIONS (REMOVAL OF TEETH)
I give my consent for the doctor to perform the extraction/oral surgery to treat and possibly correct my diseased oral tissue, or other procedures deemed necessary or advisable as necessary to complete the planned operation/extraction. If left untreated, the risks to my health may include (but are not limited to) swelling, pain, infection, cyst formation, gum diseases, dental decay, malocclusion, and premature loss of teeth and/or bone. My dentist has informed me of possible alternative methods of treatment.
Potential risks include, but are not limited to the following:

A. Post-operative discomfort; stretching of the corners of the mouth, with resultant cracking and bruising; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage possibly exposing crown margins; tooth looseness; delayed healing dry socket; and/or infection requiring prescriptions or additional treatment, i.e. surgery.
B. Injury to adjacent teeth, prosthesis, and/or restorations that may require additional treatment or injury to other tissues not within the described surgical area.
C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite or tempromandibular jaw joint; difficulty possibly requiring physical therapy or surgery.
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone and/or jaw fracture, or opening of the maxillary sinus requiring additional surgery.
F. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue, which may be temporary or permanent.

If any unforeseen condition should arise in the course of the operation/extraction calling for the doctor's judgment or for procedures in addition to or different from those now contemplated; I request and authorize the doctor to do whatever he may deem advisable, including referral to another dentist or specialist. (Initials__________)

5. CROWNS AND BRIDGEWORK
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 or bridgework, which may come off easily and could be aspirated, and I must be careful to ensure that they are kept on until the permanent crowns or bridgework are delivered. I understand that if my temporary crowns or bridgework come off, then it is my responsibility to return to my dentist to have them re-cemented. I realize that the final opportunity to make changes in my new crowns or bridgework including shape, fit, size and color will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crowns or bridgework, they may not fit properly and I will be responsible for any lab fees.
(Initials__________)

(TURN OVER, PLEASE)

6. DENTURES - COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit, if that visit is scheduled. I understand that most dentures require relining approximately three to six months after initial placement and yearly thereafter. The cost for these relines is not included in the initial denture fee. I further understand that due to bone loss, lack of alveolar ridge support, muscle attachments and/or other complicating factors, I may never be able to wear dentures to my satisfaction.

(Initials__________)

7. ENDODONTIC TREATMENT (ROOT CANALS)

The purpose and method of root canal therapy have been explained to me as well as consequences of non-treatment and reasonable alternative treatments. I understand that following root canal therapy, my tooth will be brittle and must be protected against fracture by placement of a final restoration (usually a post/build-up and crown) over the tooth. I also understand that sometimes root canal therapy may fail and further treatment may be necessary that might include but not limited to re-treatment, apicoectomy, or extraction.
I understand that treatment risks can include, but are not limited to the following:

A. Post-treatment discomfort, infection, restricted jaw opening.
B. Swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Separation of root canal instruments during treatment, which may in the judgment of the dentist be left in the treated root canal or bone as part of the filling material; or it may require surgery for removal.
D. Perforation of the root canal, which may require additional surgical treatment, premature tooth loos (extraction).
E. Risk of temporary or permanent numbness in the treatment vicinity.
F. The root canal filling material may be over-filled or under-filled, which may or may not affect the success/outcome of the treatment.

(Initials__________)

8. PERIODONTAL LOSS (TISSUE & BONE)

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 and maintenance visits. I understand that I have a serious condition causing gum and bone inflammation and/or loss that can lead to loss of my teeth and other related systemic complications. The various treatment plans have been explained to me, including non-surgical scaling and root planing followed by local irrigation with oral medicines and local delivery of antibiotics, or gum surgery, or replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. I understand that after following approved periodontal treatment there may still be a need for a referral to a periodontist.

(Initials__________)

9. FILLINGS

I have been advised of the need for fillings, either amalgam (silver) or composite resin (acrylic/plastic). In cases where very little tooth structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment such as root canal therapy, post/core and build-up, and crowns, which would necessitate a separate charge. I understand that my recently placed fillings may cause some sensitivity and discomfort for a duration and may be alleviated with time. However, I understand that if the symptom and sensitivity worsen, then I might need a root canal.

(Initials__________)

10. PEDODONTICS- CHILDREN'S DENTISTRY

I understand that the following procedures are routinely used in conjunciton with pediatric dentistry, as well as being accepted procedures in the dental profession. As the parent or authorized caregiver, I understand and give consent that the following procedures can be used on my child.

A. POSITIVE REINFORCEMENT - Rewarding the child who portrays a desirable behavior by use of compliments, verbal praises, or toys.
B. VOICE CONTROL - Changing the tone or increasing the volume of the doctor's voice gains the attention of a disruptive child.
C. REFERRAL TO A PEDIATRIC SPECIALIST - If the above or other techniques are ineffective in behavior management to the point that the dentist feels he cannot safely perform dental procedures on the child, he will feel compelled to refer the child to a pediatric dental specialist for further treatment.

(Initials__________)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient or Guardian's Signature ______________________________ Date ____/____/____

Doctor's Signature ______________________________ Date ____/____/____