RIVER HILLS DENTISTRY

GENERAL • COSMETIC • IMPLANTS • PERIODONTICS

4337 Lynx Paw Trail ♦ Valrico ♦ Florida ♦ 33569 ♦ (813) 654-4223

GENERAL DENTISTRY INFORMED CONSENT

Name: _____ Date: _____

1. WORK TO BE DONE

   I understand that I may have the following work done: Xrays, Cleanings, Exams, Fillings, Bridges, Crowns, Extractions, Root Canals, Dentures, Periodontal/Gum, and any other dental treatment offered at this location.

2. DRUGS AND MEDICATIONS

   I understand that antibiotics, analgesics, and other medications can cause allergic reactions including redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. The injections of local anesthetics may cause temporary or permanent nerve damage (parasthesia.) I have informed my doctor of any known allergies and all medications I am currently taking.

3. CHANGES IN TREATMENT PLANS

   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.

4. PERIODONTAL DISEASE (TISSUE AND BONE)

   Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extracting of teeth and bone replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

5. 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 (including possible crowning) may be required due to conditions found at treatment. I understand that significant sensitivity is a common after effect of a newly placed filling. There is a possibility that root canal treatment may be necessary after fillings.

6. REMOVAL OF TEETH

I understand that there are other alternatives to extractions (root canals, crowning, periodontal surgery, etc.) and I authorize the Dentist to remove any teeth necessary. 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 infections, dry socket, sinus involvement, loss of feeling in my teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time or fracture of jaw or bone. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which are my responsibility.

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save a tooth and that complications can occur from the treatment. Occasionally the canal filling material may extend through the end of the root, which may or may not affect the success of treatment, and which may require additional treatment. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. I understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that a specialty care may be indicated if complications arise.

8. CROWNS, BRIDGES, AND 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 may come off 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 veneer (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days of tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or veneer. I understand there may be additional charges for remakes due to my delaying permanent cementation.

9. DENTURES AND PARTAILS

I understand the wearing of dentures and partials is difficult. Sore spots, altered speech and difficulty in eating are common problems. The final opportunity to make changes to my dentures will be at the try in visit when the teeth are in the wax. Immediate dentures/partials (placement of denture/partial immediately after extractions) may be painful. Immediate dentures/partials may require considerable adjusting and several relines. A permanent reline may be needed later. In severe cases a completely new denture may be needed. This is not included in the denture/partial fee. I understand that it s my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result on poor fitting dentures/partials. If a remake is required due to my delays, there may be additional charges.

I understand that dentistry is not an exact science so therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that this is only an estimate and subject to modification depending on unforeseen or 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 payment of dental fees. I agree to pay any attorney's fee collection fee or court costs that may be incurred to satisfy this obligation.

Should any dispute arise over dental services provided to me as to whether any dental services rendered were allegedly unnecessary, unauthorized or was improperly, negligently or incompetently 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.

CONSENT: I have read, understand and agree to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original, forever. I am of legal age and legally competent to make this assignment.

X _____

Signature of patient (or parent/guardian if minor)

Date: _____

X _____

Doctor's Signature

Date: _____