## STATEMENT OF CONSENT FOR AMALGAM REPLACEMENT PROCEDURES

1. I hereby authorize Dr. ______________________ and/or other dentists or assistants as may be selected by him/her to treat my condition(s). The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure as follows: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
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2. I have been informed of my current dental diagnosis and of possible alternative methods of treatment (if any).
3. I further understand that this is an elective procedure that other forms of treatment or no treatment at all are choice that I have, and I have discussed the known risks of these other forms of treatment with my dentist.
4. I understand that replacement of dental amalgam in a non-allergic patient does not indicate that the doctor is of the opinion that amalgam is a health hazard.
5. The doctor has explained to me that there are certain inherent and potential risks in ANY treatment plan or procedure. We no not expect these to occur, but there is that possibility. In this specific instance such risks include, but are not limited to, the following:
   A. Nerve inflammation leading to hot and cold sensitivity
   B. The need for endodontic therapy (root canal treatment)
   C. Cracked cusps
   D. A shorter length of serviceability of the restoration with the need for more frequent replacement
   E. In cases where the previous restorations (fillings) are very large, the use of cast or full coverage crowns, or bonded porcelain are suggested
6. It has been explained to me that, during the course of the procedure(s), unforseen conditions may be revealed that necessitate and extension of the original procedures or different procedures(s) than those set forth in paragraph 1 above. I, therefore, authorize and request that the persons described in paragraph 1 above perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph 6 shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.
7. I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described in paragraph 1, and to the use of such anesthetics as may be advisable with the exception of: ______________________________ to which I said I was allergic. I recognize that there are always risks to life and health associated with anesthesia and such risks have been explained to me.
8. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device until I have recovered from the effects of the anesthetic medication and drugs that I may have been given in the office for my care.
9. It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.
10. I agree to cooperate completely with the recommendations of the doctor while I am under his/her care, realizing any lack of same could result in a less than optimum result and that failure to follow the doctor's suggestions and directions could be even life threatening.
11. I have been given ample opportunity to ask questions and any questions I have asked have been answered in a satisfying manner.
12. I certify that I read and write English and fully understand this consent. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT.

INFORMATIONAL USE ONLY

_________________________________ _______________
Signature Date

_________________________________ _______________
Witness Date

_________________________________ _______________
Dentist Date

**INFORMATION INFORMED CONSENT**

# APICOECTOMIES AND APICAL SURGERY

**I UNDERSTAND that APICOECTOMIES include possible inherent risks such as, but not limited to the following:**

1. **Injury to the nerves:** This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness could occur and may be of a temporary nature, lasting a few days, a few weeks; a few months; or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.

2. **Bleeding, bruising, swelling:** Bleeding may last several hours. If bleeding is profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time.

3. **Infection:** No matter how carefully surgical sterility is maintained, it is possible, due to existing non-sterile or infected oral environment, infections may occur postoperatively. At times, infections may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon possible should be received.

4. **Sinus or Mandibular Canal Involvement:** In some cases, the roots of the teeth that are going to be apically treated lie in closer apposition to the Maxillary Sinuses or to the Mandibular Canal, including the Mental Foramen than they appear to be radiographically. Even though a rare occurrence, there is a slight possibility that the Maxillary Sinus or the Mandibular Canal may be perforated, or the nerves emanating from the Mental Foramen may be traumatized during the surgical procedure involved with removing the apices of the infected teeth.

5. **Injury to adjacent teeth or adjacent roots:** There is a possibility of injury to an adjacent tooth or to roots of teeth during the procedure. If an adjacent tooth or roots of teeth are inadvertently nicked or otherwise damaged during the surgical procedures, conventional endodontic treatment, endodontic surgery, or extraction may be required.

6. **Bacterial Endocarditis:** Because of normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and Bacterial Endocarditis (an infection of the heart) could occur. Pre-existing conditions causing valvular dysfunction are the most likely cause of this complication. It is my responsibility to inform the dentist of any heart problems known or suspected.

7. **Failure:** Even though the surgical procedure is properly performed, there exists the possibility that the attempt to preserve the tooth will fail due to the tooth and tissues not responding as they should, thereby necessitating extraction of the tooth.

8. **Unusual reactions to medications given or prescribed:** Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics that may be necessary to control infection can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.

9. **It is my responsibility to seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given me.**

INFORMATIONAL USE ONLY

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment known as Apicoectomy and have received answers to my satisfaction. I have been given the option of seeking care from any oral-maxillofacial surgeon; a periodontist; and/or endodontist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorized Dr. ______________________ and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

___________________________________ ___________________________________ _________________

Patient's name (please print) Signature of patient, legal guardian or authorized representative Date

Tooth No.(s) ________________________

___________________________________ ___________________________________ _________________

___________________________________

Witness to Signature Date

## APPLIANCE RELEASE AND PAYMENT AGREEMENT

The appliance being made for my child is a temporary appliance used to maintain proper tooth space or to provide better aesthetics or both.

**Release**

I understand that if my child does not have periodic examinations, problems may occur to the teeth to which the appliance attaches. For example, a band may become loose, which may cause tooth decay or other problems if left unattended. I agree not to hold Dr. ______________ responsible for any problems or additional treatment cost arising from such problems. I acknowledge that it is my responsibility to see to it that Dr. ______________ is notified of any problems or concerns of which I become aware regarding the appliance or instructions for its use and that Dr. ______________ is not responsible for matters arising from any failure to keep him informed.

INFORMATIONAL USE ONLY

**Payment Agreement**

I will pay $________ at the initial appointment at which impressions will be take for the appliance. I will pay the balance, less any amount for which there is insurance coverage, when the appliance is delivered. I also agree that after impressions have been taken for the appliance, I will be responsible for the total cost of the appliance even if I choose not to have the appliance placed.

I have read and fully understand this Appliance Release and Payment Agreement.

_____________ _______________________________________________

Date (Signature of parent)

# BLEACHING TEETH
# OUTSIDE THE DENTAL OFFICE

Hydrogen peroxide has been used for many years to bleach teeth. In the past, application of hydrogen peroxide was usually accompanied with heat and/or light. Recently peroxide has been applied to teeth in trays at home, supervised by patients. This technique does not require heat or light. Although the results of the procedure do not appear to be different from more traditional techniques, a few potential reversible negative events are described below. Also, as with other forms of tooth bleaching, occasionally upgrade bleach applications may be necessary in future years.

INFORMATIONAL USE ONLY

**<u>Patient instructions (nighttime use only)</u>**

1. At bedtime, brush and floss teeth. Rinse mouth well.
2. Place 2-3 drops of bleaching gel into each space in the tray for every tooth to be lightened.
3. Insert tray into mouth over teeth, expectorate excess gel, and wear loaded tray during sleep every night.
4. Rinse tray each morning, and clean teeth as usual. Fluoride-containing toothpaste and mouth rinse may be used if desired.
5. Discontinue bleach if tooth sensitivity, gum irritation, or any other negative event occurs. Notify your dentist with the problem immediately.

The average time for optimum color change to occur using nighttime bleaching technique is six weeks, although effects may be noticed as early as two weeks. Observation appointments are necessary every 7-10 days to check the progress of the bleaching.

**<u>Patient instructions (increased bleach time)</u>**

1. In addition to using the bleaching trays each night, you may decrease the time necessary for your bleach by applying the solution in your trays up to several 2-hour periods daily.
2. An ideal additional time for many persons is the two hours before retiring.
3. Total bleaching time per day, including the 7 or 8 hours during sleep, should not exceed 18 to 20 hours. Most patients find that 1-3 total periods per day (including night) is not objectionable.

I HAVE READ AND UNDERSTAND THE ABOVE DIRECTIONS AND CAUTIONS:

__________________________________________ ______________________

Signature Date

**INFORMATION INFORMED CONSENT**

# ROOT CANAL THERAPY

**I UNDERSTAND that ROOT CANAL THERAPY includes possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of results have been made nor are expected:**

1. **The teeth treated may remain tender or even quite painful for a period of time,** both during and after completion of treatment. If pain is severe or swelling occurs, please call our office immediately. There is also a possibility of numbness occurring and/or persisting in the tongue, lips, teeth, jaws and/or facial tissues which may be a result of the anesthetic administration or from treatment procedures. This numbness is usually temporary, but, rarely, could be permanent.

2. **In some teeth, conventional root canal therapy may not be sufficient.** If the canals are calcified, roots are excessively curved or inaccessible, inadvertent pulp chamber or root perforation may occur, requiring referral to a specialist. If there is infection in the bone surrounding the tooth, referral to a specialist for extraction or a surgical Apicoectomy may become necessary.

3. **Root canal treated teeth must be protected.** During and after treatment, your tooth in most instances will have only a temporary filling. Should this come out, please call us for a replacement. It is advisable to crown or cap a tooth as soon as possible after root canal treatment. Root canal treated teeth may become brittle and, due to undermined or reduced tooth structure, leave the teeth subject to cracking or fracturing. Crowning or capping the treated tooth or teeth is the best precautionary measure to help avoid this from occurring.

4. **Root canal therapy is not always successful.** Many factors influence success: adequate gum tissue attachment and bone support; oral hygiene; previous and present dental care; general health; trauma; pre-existing, undetected root fractures, accessory or lateral canals, etc. Even though a tooth may have appeared to be successfully treated, there is always the possibility of failure making additional root surgery (Apicoectomy) or extraction necessary. If a bridge abutment or crowned tooth requires endodontic therapy, the chance of perforation is enhanced due to obscured anatomy.

5. **A crown abutment or crown (cap) may be damaged or destroyed** during rubber dam application, access preparation, or other procedures as part of endodontic therapy. Porcelain is particularly susceptible to fracture or cracking, and an existing porcelain cap may have to be remade, particularly if the pre-existing cap is all porcelain in design.

6. **Root fracture is one of the primary reasons for root canal failure.** Unfortunately, “hairline” cracks are almost always invisible and undetectable. Causes of root fracture are trauma, inadequately protected teeth, cracking of the tooth, large fillings, improper bite, excessive wear, habitual grinding of teeth, etc. Root fracture after or prior to treatment usually necessitates extraction.

7. **There are alternatives to root canal treatment.** These alternatives (though not of choice) include: no treatment; extraction; extraction followed by bridge or partial denture placement; and/or extraction followed by implant and crown placement.

8. **Because of the fragility and small diameter of root canal instruments** used in root canal treatment, there exists the possibility of instrument separation (breakage) which may or may not be detected at time of treatment.

9. **Medications.** Analgesics and/or antibiotics may need to be prescribed depending on symptoms and/or findings. Prescription drugs must be taken according to instructions. Women on oral contraceptives must be aware that antibiotics cause these contraceptives to be ineffective. Other methods of contraception must be utilized during the treatment period.

10. **ONCE TREATMENT IS BEGUN, it is absolutely necessary that the root canal treatment must be completed. One or more appointments may be required to complete treatment. It is the patient’s responsibility to seek attention should any unanticipated or undue circumstances occur. Also, the patient must diligently follow any and all preoperative and/or postoperative instructions given by the dentist and/or staff.**

INFORMATIONAL
USE
ONLY

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I have been given the option of seeking this treatment from a specialist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorized Dr. __________________________ and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

| ______________________________ | ______________________________ | ____________________ |
|---|---|---|
| Patient’s name (please print) | Signature of patient, legal guardian or authorized representative | Date |
| Tooth No.(s) ____________________ | | |
| ______________________________ | ______________________________ | ____________________ |
| ______________________________ | Witness to Signature | Date |

# CONSENT TO PERFORM ENDODONTICS

This authorization and consent for treatment is given to Dr. _______________________ and staff after first having had a full explanation of the proposed treatment. This disclosure is not meant to frighten me. It is simply an effort to make me better informed so I may give or withhold my consent.

The doctor has explained that his/her diagnosis is _____________________________ and has advised me than in his/her opinion root canal treatment is indicated. The doctor has advised me in his/her opinion and the consequences of not treating this condition include but are not limited to: worsening of the disease, infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease manifestations. The doctor has advised me of alternative treatments, benefits, and risks which include are not limited to: extraction of the infected tooth (teeth) or not treatment or referral to a specialist (endodontist). I, however, believe that the root canal as noted above would be my preferred choice of treatment.

INFORMATIONAL USE ONLY

The doctor has advised me that there are certain risks and potential consequences of any treatment and such risks would include but are not limited to:

- A certain percentage (approximately 5-10%) of root canals fail, necessitating re-treatment, root surgery (with a referral to a specialist), or extraction.
- Postoperative discomfort, swelling, restricted jaw opening which may persist several days or longer.
- Breakage of root canal instrument during treatment which may, in the judgement of the doctor, be left in the treated root canal or require surgery by a specialist for removal.
- Perforation of the root canal with instruments which may require additional surgical corrective treatment by a specialist or result in loss of tooth.
- Premature loss of tooth due to progressive periodontal (gum) disease.
- Root canal treatment relies heavily on radiographic information. Since radiographs are essentially 2-dimensional shadows which provide reliable but not infallible information, this may lead to root canal failures.
- Successful completion of the root canal procedure does not prevent future decay or fracture. The endodontically treated tooth will be more brittle and may discolor.
- In most cases, a crown and post filling is recommended after completion of the root canal to prevent fracture and/or improve esthetics.

The endodontic fee is $__________ and does not cover alloy, plastic restoration, or crown.

I have read and understand the above and had all my questions answered to my satisfaction. I agree to proceed with the recommended root canal therapy.

________________________________________ ____________________

Patient's Name (printed) Date

________________________________________

Patient's Signature

**PATIENT INFORMATION AND CONSENT FOR ENDODONTICS (ROOT CANAL THERAPY)**

**What is root canal therapy and what are its benefits?**
Root canal therapy is the procedure of cleaning out deeply decayed or infected tissue from inside the tooth followed by filling of the "canal(s)" or hollow tube(s) that remains once the tissue is cleaned out. It is the option offered when extracting or pulling the tooth and is oftentimes the only alternative. Root canal therapy allows the tooth to remain in the mouth and contribute to a sound, healthy and functional dentition for many years, if not a lifetime.

**What are the possible complications of treatment?**
With a success rate that is in the 90-95% range, endodontics is one of the most reliable dental or medical procedures. However, there can be no absolute guarantee regarding treatment success. Some complications can include:

1. Possibility of perforations of the tooth's crown or root. This can ultimately lead to surgical treatment by a specialist, or possible loss of the tooth.
2. Damage to existing restorations (fillings or crowns) which may necessitate replacement at the patient's expense.
3. Possibility of the separation or breaking of instruments which may not be removable, and which may cause pain, swelling, and/or infection, which may result in the loss of the tooth.
4. Root canal treatment relies heavily on radiographic (x-ray) information. Since radiographs are essentially two dimensional images of a three dimensional object, they provide good but not infallible information about the shape of the tooth, which can lead to endodontic failure, which may necessitate re-treatment or surgical treatment at a specialist's office.
5. Host resistance. In much the same manner that some people catch a lot of colds, some people's immune systems are not as strong as others, which can contribute to endodontic failure due to persistent infection.
6. Some teeth have very calcified (narrow) or curved canals that may not allow for endodontic therapy to be completed to the end of the root. This may necessitate the future need for surgery by a specialist, or loss of the tooth. Sometimes a general dentist will refer a patient to a specialist if he/she finds a that they cannot successfully get instruments to the end of the root. If that occurs, you will be informed by your dentist, and no fee higher than a pulpotomy fee (a procedure where just the top part of the nerve tissue is taken out in emergencies and certain other instances) will be charged to the patient.
7. Some teeth may have fractured roots that are undetectable at the time of treatment. Unfortunately, this usually results in loss of the tooth.

**IN ANY OF THE ABOVE CIRCUMSTANCES WHERE A SPECIALIST'S SERVICES ARE NEEDED, IT IS UNDERSTOOD THAT IT IS THE PATIENT'S RESPONSIBILITY FOR PAYMENT OF FEES AT THAT SPECIALIST.**

INFORMATIONAL USE ONLY

8. Despite all efforts by a general dentist, or a specialist, some complications could result, which include, but are not limited to:
   1. allergic reactions to medications, materials, or drugs used;
   2. pain;
   3. swelling;
   4. infection;
   5. sensitivity to pressure during or after the canal(s) is sealed;
   6. paresthesia or long-term numbness.
9. Successful completion of a root canal *does not prevent further decay or fracture*. The treated tooth will need subsequent treatment with a permanent filling, or a crown buildup and crown, or a post and crown, depending on the individual tooth. The costs for doing any of these procedures are not included in the fee for performing a root canal.

**What alternatives are there?**

1. You can do nothing. This isn't a very good option for very long, and is not recommended, but choosing not to have a problem dealt with is a patient's right.
2. You can have the tooth extracted. This leaves a space which may be unacceptable due to cosmetics, phonetics (speech) and the possibility of other teeth moving into that space, causing problems with occlusion (your bite) or possibly exacerbating a gum-disease problem. That space can

I have read and understand the above and had all my questions answered to my satisfaction. I agree to proceed with the recommended root canal therapy.

______________________________ ____________________
Patient's Name (printed) Date

______________________________
Patient's Signature

# PATIENT CONSENT FOR ENDODONTIA
# (Root Canal Therapy)

I fully understand that because of my dental problems, which are: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ,
root canal therapy is indicated. I understand the reasons for treatment which can be the removal of infection or the exposed nerve end to prevent re-infection.

GENERAL INFORMATION

Endodontics is a branch of dentistry concerned with diagnosis, treatment, and prevention of diseases of the dental pulp and its surrounding tissues. Root canal therapy is performed on a tooth that is infected or if the nerve has been exposed due to pulpitis (inflamation of the pulp of a tooth), abscess (a localized collection of pus), prosthetics reasons, or failed previous treatment.

ALTERNATIVES

The alternative treatment of tooth extraction which is the removal of the tooth has been fully explained to me; as well as the option of no treatment. The possible results if no treatment is performed have been fully explained to me. I also understand the possible consequences of not completing endodontic treatment once it is initiated.

INFORMATIONAL

SYMPTOMS AND RISKS

I understand that during or after endodontic treatment there is a possibility the following may occur: pain, swelling, infection, reinfection, cold sores, canker sores, irritation or injury to the oral mucosa, periodontal involvement (loss of bone and tooth mobility due to infection), breakage of instruments (such as files) within the root canal of the tooth, calcified canals preventing endodontic therapy through the entire length of the root, perforation of the crown or root of the tooth (by dental instruments or as a pre-existing condition), allergic reactions to dental materials or medications.

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SUCCESS

I also understand that root canal therapy is not 100% successful and that the endodontic procedure may have to be repeated and/or an additional minor surgical procedure may be required. The success rate is between 85% and 95%. I understand that the treatment will involve several appointments to complete the procedure. I understand the benefit of saving a tooth which might otherwise need extracting.

I UNDERSTAND THAT AFTER ENDODONTIC TREATMENT, the tooth will require restorative treatment. I understand that although root canal treatment can save the tooth, the procedure weakens the tooth and causes the tooth to become more brittle, turn dark in color, and more susceptible to fracture. Therefore, the tooth should have a crown or porcelain inlay/onlay restoration upon completion of the endodontic treatment.

I HEREBY CERTIFY THAT I FULLY UNDERSTAND THIS AUTHORIZATION for endodontic treatment. I have been given the opportunity to ask questions and have been given satisfactory answers. I am aware that the practice of dentistry and endodontics is not an exact science, and I acknowledge that no guarantees have been made to me as a result of the procedures authorized above. I hereby authorize Dr. ________________________ and staff to perform examinations, diagnostic procedures and treat accordingly with root canal therapy.

_______________________________
Date

_______________________________ _______________________________
Patient's Name (printed) Witness (to signature only)

_______________________________ _______________________________
Patient's Signature Witness (to signature only)

**ENDODONTIC (Root Canal Therapy)**
**INFORMED CONSENT**

I hereby consent to the endodontic treatment procedure for myself (or my child _____________) on tooth number(s) ________________ to be performed by Dr. ___________________________. I understand the nature of the problem causing the need for treatment (that the nerve tissue within the tooth is dead or dying and causing acute or potential risk of infection in the bone surrounding the tooth), and I understand the reasons for treatment (removal of the nerve tissue to relieve or prevent infection). The alternative treatment of extraction of the tooth has been explained to me as well as the potential consequences if no treatment is performed. I also understand the possible risks of not completing this treatment once it is begun.

I understand that during or after endodontic treatment there is a possibility the following may occur: pain, swelling, infection, reinfection, cold sores, canker sores, irritation or injury to the oral tissues, periodontal involvement (bone loss and tooth mobility due to infection), calcified canals preventing complete endodontic therapy, allergic reactions to dental material or medications, breakage of instruments (such as files) within the root canal or perforation of the crown or root of the tooth (by dental instruments or as a pre-existing condition) which may require surgical correction or result in the loss of the tooth.

INFORMATIONAL USE ONLY

I understand that root canal therapy is not always successful (approximately 90-95% of cases are treated successfully) and that the endodontic procedure may have to be repeated and/or an additional surgical procedure may be required at additional expense. I understand that the treatment may involve several appointments to complete, and I may loose this tooth despite all efforts to save it.

I understand that after endodontic treatment, the tooth will be more brittle, may discolor (possibly requiring bleaching or veneering), and will require restorative treatment (filling, post, buildup, and/or crown), and I have been given and estimate of fees for the completion of this work. Failure to complete this restorative treatment may result in the loss of the tooth due to fracture. I have been given the opportunity to ask questions and have received satisfactory answers. I am aware that the practice of Dentistry and Endodontics is not an exact science, and I acknowledge that no guarantees have been made to me as a result of the procedure authorized above.

______________ ____________________________________________

Date Signature of Patient (or person with authority to consent for patient)

______________ ____________________________________________

Date Signature of Dentist

______________ ____________________________________________

Date Signature of Witness

# CONSENT FOR ENDODONTIC TREATMENT

**I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.**

**I, the undersigned, have been informed of the alternatives to root canal treatment, including no treatment at all, I understand that if no treatment is provided I may experience:**

1. **The loss of the tooth;**
2. **Bone destruction due to an abscess.**
3. **Possible systemic (affecting the whole body) infection.**

**I also understand that if I choose to have root canal treatment for tooth no. ________:**

1. **A certain percentage (5-10%) of root canals fail, and they may require re-treatment, periapical surgery, or even extraction.**
2. **During instrumentation of the tooth, an instrument may separate and lodge permanently in the tooth, or an instrument may perforate the root wall. Although this rarely occurs, such an event could cause the failure of the root canal and the loss of the tooth.**
3. **A root can crack or split which may affect the outcome of the root canal therapy**
4. **When making an access (opening) through an existing crown or placing a rubber dam clamp, damage could occur and a new crown would be necessary after endodontic therapy.**
5. **Successful completion of the root canal procedure does not prevent future decay or fracture.**
6. **Temporary fillings are usually placed in the tooth immediately after the root canal treatment. Teeth which have had root canal treatment will require a permanent (outside) restoration. This may involve a filling or more extensive restorative work (pins, post, crown buildup, crown) depending on the clinical status of the tooth.**

**There are risks involved in administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the doctor of any previous side-affects of allergies from any medication.**
***Note: Antibiotics may decrease the effectiveness of birth control medication. Additional methods of birth control should be used while on antibotics.***

**I agree that I have read, had explained to me and understand this consent for endodontic treatment. I have been given the opportunity to ask questions concerning the treatment, the risks of treatment and the alternatives to treatment. After fully considering this information, I hereby consent to endodontic treatment set forth above.**

| ________________ | ________________________________________ |
|---|---|
| **Date** | **Patient or Patient's Guardian** |
| ________________ | ________________________________________ |
| **Date** | **Signature of Witness**7. |

INFORMATIONAL USE ONLY

# ROOT CANAL THERAPY INFORMED CONSENT

I hereby give permission to _______________________________ to perform root canal therapy on my tooth no. _________, and such additional procedures as are considered necessary on the basis of findings during the course of said treatment.

I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require treatment, surgery or even extraction.

I also understand root canal therapy is a filling of the internal canal of the tooth and the final outside restoration will be necessary following the root canal filling. Since the blood supply is removed from the tooth, it has a tendency to become more brittle and may discolor so the usual restoration choice is a filling and a crown. A normal filling may suffice in some instances.

INFORMATIONAL USE ONLY

I understand that a series of appointments will be necessary to complete the root canal therapy, as well as other appointments for the final restoration. I am also aware that I may have continuing temporary symptoms throughout the treatment. Those symptoms may include:

8. Swelling
9. Pain
10. Infection
11. Drainage
12. Fever
13. Numbness

I understand that I should notify the dentist if any of these symptoms are present for more than 48 hours.

I consent for this procedure to be done with the following anesthesia and/or medications:

1. Local anesthesia only
2. Local anesthesia with oral preoperative sedative
3. Local anesthesia with nitrous oxide and oxygen

I also understand that the administration of anesthesia and/or medications carry certain inherent risks, such as, but not limited to:

1. Drug interactions and/or side effects
2. Bruising and/or numbness including the site of the injections

I acknowledge full responsibility for the payment of these services and agree to pay for them in full at or before completion, unless other specific arrangements have been made.

______________________________________________________

Date Signature of Patient or Patient's Guardian

______________________________________________________

Date Signature of Witness

I understand that by the very nature of the proposed treatment and uniqueness of myself as an individual, that no one can predict the certainty of any outcome or success and that even in the event of root canal treatment, my condition may worsen. I understand that no guarantees or assurances have been given to me and that the proposed treatment(s) or alternatives, if any, would fully satisfy my expectations. I believe that this is in my own best interest to proceed with the root canal treatment.

I have had ample opportunity to ask questions about root canal therapy, alternatives, and risks and I discussed with the doctor my medical and health history indicating problem(s), illness, and/or allergies.

INFORMATIONAL USE ONLY

I certify that I have read, discussed, and fully understand the authorization for root canal therapy. I accept the risks of substantial harms, if any, in hopes of obtaining the desired beneficial results of root canal therapy.

______________________ ________________________________
Date Signature of Patient

______________________ ________________________________
Date Signature of Dentist or Witness

# INFORMED CONSENT FOR EXTRACTION

I understand that there may be alternatives to the extraction of teeth and after the doctor's explanation, I have chosen extraction. There are various normal complications that can occur despite all efforts to the contrary as a result of the extraction(s) which include but are not limited to:

- Allergic reaction to medications or anesthetics used
- Pain, swelling, infection, bruising, bleeding
- Stiffness of the nearby muscles
- Numbness
- Root tips may fracture and be left in place or could be displaced into the sinuses and/or spaces nearby
- Dry sockets, aspiration and/or swallowing of foreign objects
- Damage to adjacent teeth and/or restorations

INFORMATIONAL USE ONLY

I further understand that this procedure can also be performed by a specialist and prefer that this treatment be rendered in this office by a general dentist.

The dental care and treatment to be performed has been explained to me and I understand what is to be done and that there is no warranty or guarantee as to any result and/or cure. I may ask the attending dentist for a more complete explanation.

This is my consent for the extraction, anesthetics, and x-rays to be taken.

I have read and understand the above and have had all my questions answered to my satisfaction and I agree to proceed with the recommended extractions(s).

______________________________ ________________________________

Date Signature

# INFORMED CONSENT AND PERMISSION FORM

Before you give your permission for the removal of teeth, removal of impacted teeth (those that are "buried" or beneath the gums), or other dental treatment, and for the administration of certain anesthetics, you should understand there are certain associated risks.

The common risks are (but not limited to):

1. Drug reactions and side effects
2. Damage to adjacent teeth or fillings
3. Post-operative infection
4. Post-operative bleeding that may require treatment
5. Possibility of a small fragment of root being left in the jaw when its removal would require extensive surgery
6. Delayed healing (dry socket) necessitating frequent post-operative care
7. Possible involvement of the sinus during removal of upper molars which may require additional treatment surgical repair at a later date.
8. Possible involvement of the nerve within the lower jaw during the removal of lower molars resulting in temporary (but possible permanent) tingling or numbness of the lower lip, chin or tongue on the operated side.
9. Bruising and/or vein inflammation at the site of administration of intravenous medications which may require further treatment
10. Other: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I was given the option of different anesthetic techniques, and I consent for the following anesthetics to be used:

_____ Local anesthesia
_____ Local anesthesia with oral pre-medication
_____ Local anesthesia with intravenous sedation
_____ General anesthesia/hospital operating room

I hereby acknowledge I have completely read the foregoing; have discussed any questions or concerns which I may have regarding my proposed surgery/dental treatment, and have been given satisfactory answers. I am aware the practice of dentistry is not an exact science, and no guarantees can be provided.

______________________________________________________________ (please print)
Last First Initial

________________ _______________________________________
Date Signature of patient; patient's guardian or authorized representative

________________ _______________________________________
Date Witness signature

INFORMATIONAL USE ONLY

# GENERAL DENTISTRY INFORMED CONSENT

Dentist:______________________________ Patient:______________________________

1. **WORK TO BE DONE:** I understand that I am having the following work done: Fillings ( ), Bridges ( ), Crowns ( ), X-rays ( ), Extractions ( ), Impacted teeth removed ( ), Root Canals ( ), Dentures ( ), Other ________________. (Initials ________)
2. **DRUGS AND MEDICATION:** I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, 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 my 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, periodontal surgery, etc.) And I authorize the dentist to remove the following teeth: __________________________ and any others necessary for reasons in paragraph #3. 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 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 for 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 the final opportunity to make changes in my news crown bridge, or cap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that 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 therapy will save my 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 effect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from 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 save it. (Initials ________)
7. **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that I have a serious condition, causing gum and bone inflamation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition. (Initials ________)
8. **FILLINGS:** I understand that care must be exercising 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 some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures 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 delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of 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 hereby authorize any of the doctors or 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 unforseen or undiagnosable 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 the dental fees. I agree to pay any attorney's fees, or court costs, that may be incurred to satisfy this obligation.

Signature of Patient ______________________________ Date: ______________________

Signature of Dentist ______________________________ Date: ______________________

INFORMATIONAL USE ONLY

## INFORMED CONSENT

The dental treatment necessary has been explained to me and my questions have been answered satisfactorily. I hereby authorize Dr. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . and/or such associates or assistants as he/she may designate to perform those procedures, including surgery, as may be deemed necessary or advisable to my dental treatment, including arrangement and/or administration of an anesthetic, sedative, analgesic, therapeutic and/or other pharmaceutical agent(s), including those related to restorative, palliative, surgical, anesthetic, sedative analgesic, medicinal or drug treatment(s) and do voluntarily assume the associated possible risks.

The fee for these services has been explained to me and is satisfactory. I recognize that in the case of a minor or other legally incompetent patient, "I" or "me" refers to the parent or other legal representative of such patient.

INFORMATIONAL USE ONLY

___________________________________ Patient or legal representative Date ________________

___________________________________ Witness

________________ Date

# INFORMED CONSENT

The dental treatment necessary has been explained to me and my questions have been answered satisfactorily. I hereby authorize Dr. ________________________ and/or such associates or assistants of choice my consent to the performing of the treatment and whatever procedure(s), including surgery, may be deemed necessary or advisable by him/her/them to the planned operation(s).

I understand the hazards or risks in connection with these procedure(s), such as bleeding; swelling; bruising; infection; tingling or numbness of the lips, tongue, gums and/or face; loss or damage to other teeth or restorations; root or tooth into the sinus; oral antral fistula; maxillary sinusitis; possible mandibular fracture; and postoperative hemorrhage and discomfort.

INFORMATIONAL USE ONLY

I understand I am not to operate any vehicle or hazardous devices or drink alcoholic beverages for at least six (6) hours or until fully recovered from the anesthetic or medication. I agree to the use of a local or general anesthetic, sedation and analgesia, depending on the judgement of the doctor(s) involved in my case.

I have been informed of the possible complications of the treatment, including surgery, anesthesia, drugs and medications. I also understand the risk of drug and/or anesthetic reactions to include possible phlebitis or altered sensation of skin and arm and/or hand. I have been given the opportunity to ask questions regarding the treatment and/or surgical procedure(s) and have received answers to my satisfaction and understanding. I do voluntarily assume the possible associated risks.

The fee for these services has been explained to me and is satisfactory. By signing this form, I am freely giving my informed consent to the necessary treatment, including surgery.

___________________________________ ________________

Patient or legal representative Date

___________________________________ ________________

Witness Date

# INFORMED CONSENT

I am aware that the practice of dentistry is not an exact science, that the very nature of the treatment an my uniqueness as an individual require that no predictions can be made. I acknowledge that no guarantees have been made to me. I believe it is in my best interest to proceed with my chosen treatment, as opposed to any alternatives which may exist. I have had ample opportunity to ask any questions I might have and have had them answered to my satisfaction. I agree to abide by the doctor's post-operative instructions and that my failure to properly care for my oral health may lead to further complications. I have had the opportunity to discuss with the doctor my overall health and medical history. I accept the risks of subsequent harms, if any, in hopes of obtaining the desired beneficial results of this treatment.

INFORMATIONAL USE ONLY

The risks involved with anesthetic and the treatment itself have been explained to me and I do give my free voluntary informed consent to the same.

| | |
|---|---|
| Signature of patient or person authorized to consent for patient | Date |
| Signature of dentist | Date |

# INFORMED CONSENT

PATIENT: ______________________________________________ DATE: ______________________

1. I, __________________________, authorize Dr. ______________________ and/or such assistants as may be selected by him/her to attempt to remedy the following condition(s) or symptom(s) which appear indicated by the diagnostic procedure(s) already performed: ..............................................................................................
..............................................................................................................................
..............................................................................................................................
..............................................................................................................................
2. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the surgery or dental procedures(s).
3. I further acknowledge that the only statements or representations upon which I have relied to consent to this surgery or dental procedure(s) are those contained in this form.
4. The condition(s) listed in paragraph 1 have been explained to me, and I understand the nature of the surgery, dental procedure(s) and anesthetic/sedation procedure(s) to be as follows: ..................................................................
..............................................................................................................................
..............................................................................................................................
..............................................................................................................................
5. I have been advised of the availability of, and risks inherent in the following alternate method(s) of treatment:
..............................................................................................................................
..............................................................................................................................
..............................................................................................................................
6. I recognize the need for my dentist to exercise his/her professional judgment on my behalf and I therefore specifically authorize my dentist to select alternate methods of treatment based on my condition as disclosed during the procedure(s) authorized by my execution of this form, including conditions which were unknown at the time the surgery or dental procedure(s) were begun.
7. I understand that there are certain inherent risks and consequences that may be associated with any surgical, dental or anesthetic/sedative procedure(s). I understand that not every conceivable hazard can be listed. I realize the following possibilities exist, however infrequent or rare: allergic reactions to medications, anesthetics, etc.; drug interactions and side effects; excessive bleeding (during the procedure and/or after the procedure); postoperative bruising and discomfort; blood clots anywhere in the body; postoperative infection or bone inflammation; possible involvement of the sinus of the upper jaw during removal of upper back teeth, requiring possible surgery for repair at a future date; possible involvement of the nerve withing the lower jaw during removal of lower teeth, resulting in usually temporary but sometimes permanent numbness and/or tingling in the lower lip and/or tongue; fracture or dislocation of the jaw; bruising and/or vein inflammation at the site of injections; damage to adjacent teeth, restorations and/or gum tissue. THESE ARE NOT PROBABLE RESULTS, THEY ARE STATISTICAL POSSIBILITIES.
8. I am also aware that certain specific risks and consequences may be associated with the surgery, dental procedure(s) and anesthesic/sedative procedure(s) outlined in paragraph 4, including: ............................................
..............................................................................................................................
..............................................................................................................................
..............................................................................................................................
9. Knowing these risks, I consent to the surgery, dental procedure(s) and anesthetic/sedative procedure(s) outlined in paragraph 4.

INFORMATIONAL USE ONLY

________________________________________________ ______________________

Signature Date

# CONSENT FOR GINGIVAL AUGMENTATION SURGERY

I hereby authorize Dr. ___________________________ (herein called Doctor) to perform gingival augmentation surgery on myself.

**Diagnosis:** After a careful oral examination and study of my dental condition, my periodontist has advised me that I have significant gum recession. With this condition, further recession may occur. In addition, for fillings at the gumline, it could be important to have sufficient width of attached gum to withstand the irritation caused by the fillings or their edges. Gum tissue may also be placed to improve appearance and to protect roots of teeth.

INFORMATIONAL USE ONLY

**Recommended Treatment:** In order to treat this condition, my Doctor has recommended that gingival augmentation procedures be performed in areas of my mouth with gum recession. A local anesthetic will be administered in addition to medications deemed appropriate by my Doctor. This surgical procedure involves the transplanting of a thin strip of gum from the root of my mouth or from the adjacent teeth. The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed as to partially cover the tooth root surface exposed by the recession. A periodontal bandage or dressing may be placed.

An alternative technique consists of the placement of a bone regenerative material (human bone obtained from a tissue bank) and a non-restorable membrane on the root surface. In that case, the membrane requires a small surgical procedure after about six weeks to remove the membrane.

**Expected Benefits:** The purpose of gingival augmentation is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Another purpose of this procedure may be to cover exposed root surfaces, to enhance the appearance of teeth and gum line, or to prevent or treat root sensitivity or root decay.

**Principal Risks and Complications:** Some patients do not respond successfully to gingival augmentation. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during healing. IN such a case, the attempt to cover the root surface may not be completely successful. In some cases, it may result in more recession with increased spacing between the teeth. I understand that unforseen changes may lead to a change in my dental treatment plan. This may include, but is not limited to: (1) the need for additional dental work, or (2) modification of the planned dental work.

I understand that complications may result from the surgery and/or any drugs used. These complications may include, but are not limited to, infection; bleeding; swelling; pain; temporary discoloration of my face; increase tooth looseness; tooth sensitivity to hot, cold, sweet or acidic foods; shrinkage of the gum upon healing, resulting in elongation of some teeth and greater spaced between some teeth. Allergic reactions and accidental

swallowing or inhaling of foreign matter are also possible. The duration of complications can not be determined, and complications may be irreversible.

No method can accurately predict or evaluate have my gum and bone will heal. There may be a need for a second procedure if the initial results are not satisfactory. The success of gingival augmentation can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my Doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have now or have had at any time in the past.

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**Alternatives to Suggested Treatment:** My periodontist has explained alternative treatments for my gum recession. These include no treatment; continued monitoring for progressive recession; and modification of technique for brushing my teeth. Principal risk with any of these alternatives includes continued recession with further exposure of the root and possible tooth loss.

**Necessary Follow-Up and Self-Care:** It is important for me to: (1) abide by the specific prescriptions and instructions given by my Doctor, and (2) see my Doctor and my regular dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. Adequate daily oral hygiene performed with a non-traumatic method of brushing my teeth is essential for the success of the procedure. Although my Doctor informs me when the next periodic visit is needed, I am responsible for contacting the Doctor's office to make appropriate appointments.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. However, there is a risk of failure, relapse, additional treatment, or worsening of my present condition resulting in the loss of my teeth despite the best of care.

Publication of Records: I authorize that my dental records, slide, x-rays or any other information pertaining to my treatment to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public.

I have read this entire form and understand everything explained in it. I have had the opportunity to ask the doctor about any questions I may have about the treatment, the risks of surgery, the alternative treatment methods and the substantial risks of the alternative treatment methods. The doctor has answered all my questions. I authorize the Doctor and whomever they may chose as their assistants to perform the proposed periodontal surgery.

| Signature | Date |
|---|---|
| Witness | Date |

INFORMATIONAL USE ONLY

# INTRAVENOUS SEDATION

I, ______________________________________, consent to the use of intravenous sedation for my periodontal treatment and to the use of medications deemed appropriate by my doctor. I understand I will be conscious but deeply relaxed during the procedure.

I have been advised of the following:

1. I must arrange for someone to pick me up at the office at the conclusion of the appointment and drive me home.

2. I could experience drowsiness for up to 48 hours following the procedure. I should not drive a car or operate machinery for up to 24 hours.

3. In rare instances, an infection (phlebitis) can develop in the arm at the site of the I.V. This can be accompanied by redness, swelling and soreness of several weeks duration.

4. I understand that my pulse rate and heart rhythm (ECG) will be monitored during my procedure. Should the need arise during the procedure, medications may be utilized to reverse the effects of the sedation.

My questions have been answered to my satisfaction regarding the use of intravenous sedation for my treatment.

_________________      ____________________________________________
Date      Signature of Patient

_________________      ____________________________________________
Date      Signature of Witness

INFORMATIONAL USE ONLY

**CONSENT FOR MAXILLARY SINUS ELEVATION SURGERY**

I hereby authorize Dr. ___________________________ (herein called Doctor) to perform maxillary sinus elevation surgery on myself.

**Diagnosis:** My Doctor has told me that I have an insufficient bone height in my upper jaw to place root shaped dental implants of adequate length.

**Recommended Treatment:** In order to be able to place root shaped implants of adequate length in my upper jaw, my Doctor has recommended that my treatment include maxillary sinus elevation surgery. A local anesthetic will be administered in addition to medications deemed appropriate by my Doctor. Oral antibiotics may be prescribed.

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My gum tissue will be pulled back and an opening will be created in the wall on the side of my maxillary sinus. After access to the sinus is created, the lining of sinuses will be lifted. Underneath the lining, a bone graft will be placed. This graft may include my own bone, synthetic bone substitute, human bone obtained from tissue banks, or a combination of these. Prefabricated membranes may also be used, which, if non-restorable, require a small additional surgical procedure for membrane removal.

Dental implants may or may not be placed at the same time of the sinus lift surgery. Whether implants will be placed at the same time can not be determined with certainty before the procedure, and I understand that implant placement may have to be delayed for as long a time as my Doctor deems advisable.

I understand that unforeseen conditions may call for changes in the anticipated surgical plan. These may include, but are not limited to: (1) extraction of teeth, (2) the removal of parts of teeth, (3) inability to start or complete the sinus elevation procedure. I understand that I consent to any such changes as deemed indicated in the opinion of my Doctor. Any of these unforeseen changes may lead to a change in my dental treatment plan. This may include, but is not limited to: (1) the need for additional dental work, or (2) the modification of the planned dental work. Some complications could include the need for a referral to other dental or medical specialists.

**Expected Benefits:** The expected benefit is that sufficient bone will be available in my upper jaw to allow placement of root-shaped implants.

**Principal Risks and Complications:** I understand that complications may result from the surgery and/or any drugs used. These complications may include, but are not limited to infection, bleeding, swelling, pain, temporary discoloration of my face, increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. Rarely, nerve damage can occur and infections can spread to other parts of the body. Nose bleeds can occur and local infection can spread to the bone (osteomyelitis). Failure of the bone graft can lead to failure of implants placed in the area, or inability to place the implants at a later date. Chronic or acute sinusitis may occur as a result of this procedure. Existing sinusitis may be aggravated or recur more frequently. Complications may be irreversible.

There may be a need for a second procedure if the initial results are not satisfactory. The success of

sinus elevation procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my Doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have now or have had at any time in the past.

**Alternatives to Suggested Treatment:** Alternatives to the sinus elevation procedure include: no treatment, resulting in an inability to place implants of sufficient length in the area, (2) grafting on top of the bony ridge in the area, (3) anchorage of implants in anatomic areas behind the maxillary sinus (pterygoid plate anchorage) (4) false teeth unrelated to implants, such as removable partial and complete dentures. Principal risks are: alternative (1): premature loss of short implants; alternative (2): limited potential to obtain more bone; alternative (3): inducement of life-threatening bleeding and severe nerve damage: alternative (4): continued bone loss and inability to comfortably function with false teeth.

INFORMATIONAL USE ONLY

**Necessary Follow-Up and Self-Care:** It is important for me to: (1) abide by the specific prescriptions and instructions given by my Doctor, and (2) see my Doctor and my regular dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. It is essential that I follow the recommendations regarding the nature and timing of following implant-related treatment. I also need to inform my Doctor as soon as possible of any complications or symptoms that may relate to the sinus elevation procedure or placement of the graft implants. These symptoms or complications include, but are not limited to nose bleeds, pain, unusual feeling of sinus pressure, fever, swelling, pus formation and reactions to the medications prescribed. Although my Doctor informs me when the next periodic visit is needed, I am responsible for contacting the Doctor's office to make appropriate appointments.

**No Warranty or Guarantee:** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. The sinus elevation procedure, although not experimental, is a fairly new surgical treatment. Its long term success and potential risks and complications may not be fully known.

**Publication of Records:** I authorize that my dental records, slides, x-rays or any other information pertaining to my treatment to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public.

I have read this entire form and understand everything explained in it. I have had the opportunity to ask the doctor about any questions I may have about the treatment, the risks of surgery, the alternative treatment methods and the substantial risks of the alternative treatment methods. The doctor has answered all my questions. I authorize Dr. ___________________________ and whomever they may chose as their assistants to perform the proposed sinus elevation surgery.

Signature of Patient ___________________________________________ Date: ____________________

Signature of Witness ___________________________________________ Date: ____________________

# NITROUS OXIDE INFORMED CONSENT

I hereby give permission for Dr. ______________________ and staff to perform nitrous oxide sedation.

I understand that the administration of medication and the performance of conscious sedation with nitrous oxide carries certain common hazards, risks, and potential unpleasant side effects which are infrequent, but non the less, may occur. They include but are not limited to the following:

1. Excessive Perspiration: Sweating may occur during the procedure and you may become somewhat flushed during administration of nitrous oxide.
2. Expectoration: Removal of secretions may be difficult but can be controlled by use of suction tip.
3. Behavioral Problems: Some patients will talk excessively. You may become difficult to treat because you are so talkative, or experience vivid dreams associated with physical movement of the body.
4. Shivering: Although not common, shivering can be quite uncomfortable. Shivering usually develops at the end of the sedative procedure when the nitrous oxide has been terminated.
5. Nausea and Vomiting: This is the most frequent of the side effects of nitrous oxide sedation but its frequency is still quite low. It is important to tell the doctor, hygienist, or assistant that you are experience some discomfort. The level of nitrous oxide can be adjusted to eliminate this side effect.
6. Driving a Motor Vehicle: You may not feel capable of driving after nitrous oxide. If this occurs, we will keep you until you feel better or have you call a friend or cab to insure your safety.

INFORMATIONAL USE ONLY

I have been advised of alternative treatment, the benefits and risks which include but are not limited to:

> Fear and anxiety of the dental experience and/or avoidance of future dental appointments. These fears and anxiety, if not diminished by the use of nitrous oxide sedation, may precipitate other medical problems including fainting, palpitation and other heart-related disorders.

The benefits one can expect from nitrous oxide sedation include:

> Help with anxiety and pain, gagging and medically compromised individual.

I hereby certify that I understand this authorization and the reasons for the above named sedative procedure and associated risks. I am aware that the practice of dentistry is not an exact science. I acknowledge that every effort will be made in my behalf for a positive outcome from sedation, but no guarantees have been made to the result of the procedure authorized above.

_____________________________________________ ________________________

Signature Date

## OCCLUSAL EQUILIBRATION, COMPLETE

Complete occlusal equilibration is a dental procedure which may be performed over several visits, in which the occlusal surfaces of the teeth are meticulously altered in shape to meet predetermined criteria of an ideal occlusion. These criteria include, but are not limited to: simultaneous even contact and maximum intercuspation of all posterior teeth in centric relation position, force vectors of occlusion parallel to the long axes of the teeth, and immediate disclusion of the of the posterior teeth by anterior teeth in all eccentric movements of the mandible. The ultimate aim of this procedure is to achieve maximum relaxation of the jaw muscles during closure without mitigative alteration of the occlusal surfaces of the teeth. The object is to produce sufficient harmony between the modified occlusal anatomy of the teeth and the masticatory muscles and temporomandibular joints so that no pathology is produced within the tissues of the stomatognathic system.

INFORMATIONAL
USE
ONLY

# OCCLUSAL EQUILIBRATION

1. **PURPOSE**: Teeth and jaws do not occlude (come together) in an acceptable position for many reasons, which may include: fillings or bridges that have been placed over a period of years, orthodontics, developmental defects, oral surgery, trauma, malocclusion (poor bite), bruxism, and clenching.

   Occlusal equilibration is the mechanical adjustment of your teeth, dentures, bridges, fillings, or other oral appliances to a position that allows your lower jaw to function in a natural hinge in relation to your upper jaw without improper influence from teeth.

2. **OCCLUSAL EQUILIBRATION – IS IT HARMFUL?**: Your mouth is being equilibrated because some problem exists: pain, abnormal wear, breaking of restorations, or other situations. The problem is usually present because the teeth and/or restorations do not meet in harmony with your lower jaw at the proper position. The teeth and fillings have not "worn in" properly. Occlusal equilibration "wears" some areas mechanically and allows the teeth to meet harmoniously. It is not harmful and is beneficial.

INFORMATIONAL USE ONLY

3. **THE FUTURE:** A simple occlusal equilibration can be accomplished in a short time. Only slight future changes in your occlusion (bit) occur over a period of time because of small movements of the teeth in the jaw bones. More complex equilibrations may require several appointments, and the teeth may shift more between appointments. When your symptoms are gone and your occlusion is relatively stable, your equilibration will be finished. Placement of any new fillings in your mouth will change the way your teeth contact. The dentist accomplishing this treatment should be advised of your past occlusion problem.

4. **HOW YOUR TEETH FEEL**: After occlusal equilibration, your occlusion (bite) will feel different to you. This is to be expected. You will gradually accept this location as your new chewing position, and it will feel very good.

5. If you have questions or problems, please call us.

# INFORMED CONSENT TO OCCLUSAL EQUILIBRATION

*Selective reshaping of the chewing surfaces of teeth with the intention to reposition the mandible and stress relieve the muscle in the head and neck suspension apparatus*

_____ Direct Equilibration
_____Following Preconditioning Appliance Therapy

Patient: ______________________________ Dentist: ______________________________

I the undersigned have sought or have been referred to the above named Doctor for occlusal equilibration, which I understand is a means of altering the chewing surfaces of some or all of my teeth, so that when my teeth come together, the temporomandibular joints (jaw joints) are in good anatomical position. I fully understand the importance of the history which I have given to the Doctor, which, together with the Doctor's examination indicated that the symptoms which I have reported to the doctor may be improved and may be eliminated.

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I understand that the Doctor does not guarantee that by changing the chewing surfaces of my teeth that any result is guaranteed, and in fact, I have been informed by the Doctor that there are possible complications which, although not likely to occur, may occur, despite the exercise of the Doctor's greatest skill and care. These include but are not limited to: loss of some tooth enamel; the possibility that tooth or teeth may prove unsound and require restoration, including the replacement of existing restorations; that a tooth or teeth may require rebuilding by removing even greater amounts of tooth structure and replacing it with a crown, which may be expensive; pain in the face and jaws; chewing difficulty; joint noise; and sensitive teeth.

I further understand that additional dental services may be required in the future such as additional equilibration and any and all additional recommended dental care and treatment as set forth in the treatment plan presented by the Doctor, if one has been discussed and agreed upon. I further understand that if extensive equilibration is required that there may be some change in the appearance of the teeth and mouth and some increased sensitivity to temperature extremes. The Doctor has explained to me that there are other approaches to therapy, such as: occlusal appliance therapy, orthodontics, reconstructive dentistry, and orthognathic surgery. I understand that if any of these approaches are used, additional diagnostic aids and expense would be necessary. Although all these options have been discussed and offered to me, I have rejected them in favor of direct equilibration. Finally, I have received literature explaining occlusal equilibration which has been read and understood.

I fully consent to receiving occlusal equilibration from the Doctor and to pay all reasonable and necessary charges therefore which have been previously and fully explained to me.

| ______________________________ | ______________________________ |
|---|---|
| Date | Signature |
| ______________________________ | ______________________________ |
| Doctor's Agent | Parent or Guardian (if applicable) |

# CONSENT TO OCCLUSAL EQUILIBRATION

I (we) have sought or been referred to Dr. ___________________________________ for occlusal equilibration, which I (we) understand is a means of altering the bite or contact surfaces of some or all of my teeth, so that when my teeth come together, the jaw hinge, or temporomandibular joints, are in good anatomical position. I (we) fully understand the importance of the history which I (we) have given to the Doctor, which, together with his examination, indicates that my symptoms which I (we) have reported to the Doctor may be improved and may be eliminated. I (we) understand that the Doctor does not guarantee that by changing bite surfaces, any result is guaranteed, and in fact, I (we) have been informed by the Doctor that there are possible complications which, although not likely to occur, may occur, despite the exercise of the Doctor's greatest skill and care. These include: loss of some tooth enamel; the possibility that a tooth or teeth may prove unsound and require restoration, including the replacement of existing restorations; that a tooth or teeth may require rebuilding by removing even greater amounts of tooth structure and replacing it with a crown, which may be expensive. I (we) further understand that additional dental treatment may be required in the future terms of additional equilibration, and any and all additional recommended dental care and treatment as set forth by in the Doctor's treatment plan, if one has been discussed and agreed upon. I (we) further understand that if extensive equilibration is required, that there may be some change in the appearance of the teeth and mouth, and some increased sensitivity to temperature extremes. The Doctor has explained to me (us) that there are other approaches to therapy, such as: splint therapy, orthodontics, and orthognathic surgery. I (we) understand that if any of these approaches were used, several hundred dollars of additional diagnostic aids would be necessary, namely: hinge axis location, pantographic surveys, equilibrated study casts and possibly transcranial radiographs and arthrography. Although all these options have been discussed and offered to me, I (we) have rejected them in favor of direct equilibration. Finally, I (we) have received literature explaining occlusal equilibration which has been read and understood.

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I (we) fully consent to receiving occlusal equilibration from Dr. _________________________, and to pay all reasonable and necessary charges therefore which have been previously and fully explained to me (us).

_________________________________ Date

_________________________________ Signature

_________________________________ Parent or Guardian (if applicable)

# CONSENT FOR OPERATION AND ANESTHESIA

Patient: ______________________________________________

Date: ______________________________ Time: ______________________________

1. Operation and Alternatives
   - A. I hereby authorize Dr. ____________________ and whomever he/she designates as his/her assistants to perform the following procedures necessary to treat my condition: . . . . . . . . . . . . . . . . . . . . .
   . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
   . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
   - B. I understand the reason for the procedure is: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
   . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
   - C. Alternatives include: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
   . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
   - D. It has been explained to me that conditions may arise during this procedure whereby a different procedure or an additional procedure may need to be performed and I authorize my surgeon and his/her assistants to do what they feel is needed and necessary.
   - E. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.
   - F. I consent to the examination and disposal by my surgeon and/or pathologist of any tissue or body parts which may be removed.

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2. Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reaction and pneumonia. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular operation include: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

3. Anesthesia: The administration of anesthesia also involves risks, most importantly is the risk of reaction to medications causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services, with the exception of: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

4. Photography: I consent to the photographing of operations to be performed, including appropriate portions of my body for medical, scientific or educational purposes, providing my identity is not revealed by name in the descriptive texts accompanying them. This may exclude photographs of the face that are recognizable as me.

5. Patient's Consent: I have read and fully understand this consent form, and I understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED SURGERY OR TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED SURGERY OR TREATMENT, ASK NOW, BEFORE SIGNING THIS CONSENT FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM!

| | |
|---|---|
| ______________________________ | ____________________ |
| Patient signature (or parent or guardian) | Date |
| ______________________________ | ____________________ |
| Witness | Date |
| ______________________________ | ____________________ |
| Physician | Date |

# CONSENT FOR ORAL SURGERY

**RECOMMENDED TREATMENT**

I give permission to Dr. ________________________ to perform the following treatment as well as any additional procedures considered necessary on the basis of findings during the actual surgery. This permissions is for myself (or my ward or minor child) named below. I fully understand this consent for surgery and the reasons why the recommended treatment is necessary. I have been given the opportunity to ask questions regarding the recommended treatment and have been given satisfactory answers. I understand that no guarantee regarding the treatment has been made or implied.

TREATMENT ................................................................................................................................

..............................................................................................................................................

**TREATMENT ALTERNATIVES**

I elected the treatment listed above even though the following alternatives and associated risks have been explained to me.

TREATMENT ALTERNATIVES ____________________________________________________________

..............................................................................................................................................

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**ANESTHESIA/MEDICATIONS**

I also authorize the recommended treatment to be performed with the following anesthetics and/or medications:

_______ Local anesthesia only
_______ Local anesthesia with nitrous oxide and oxygen

**RISKS AND CONSEQUENCES**

I understand that there are risks associated with the administration of medications and performance of the recommended surgery such as the items checked below:

_______ Drug reactions and side effects
_______ Post-operative bleeding and pain
_______ Necessary removal of bone during tooth extraction
_______ Post-operative infection or bone inflammation
_______ Possible damage to the sinus when upper back teeth are removed which may require surgical repair at a future date
_______ Possible nerve damage when lower wisdom teeth are removed which can result in either temporary or permanent tingling or numbness in the lower lip
_______ Fracture of the mandible
_______ Jaw joint (TMJ) pain, malfunction and\or difficulty in opening mouth due to muscle spasms, following removal of the lower teeth

I agree that I have read, had explained to me and understand this consent for surgical treatment. I have been given the opportunity to ask questions concerning the treatment, the risks of treatment and the alternatives to treatment. After fully considering this information, I hereby consent to surgical treatment set forth above.

______________________ ________________________________________
Date Patient or Patient's Guardian

______________________ ________________________________________
Date Witness

# CONSENT FOR ORAL SURGERY

Patient's Name: ________________________________________ Age: _____________

I hereby give consent to Dr. ______________________________ to perform the oral surgery procedure(s) for myself or my dependent as follows: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
and such additional procedures as are considered necessary for my well being on the basis of findings during the course of said procedure(s). The nature and purpose of the procedure have been explained to me and no guarantee has been made or implied as to result or cure.

Alternative methods of treatment have been explained to me, such as: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
but I desire the treatment described above.

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I also consent to the administration of local anesthesia and the taking of any radiographs (x-rays) as indicated.

I understand that the administration of medications and the performance of surgery can carry certain common, inherent risks, or complications such as, but not limited to: bleeding; swelling; discomfort; nausea; infection; drug reaction; delayed healing; damage to other teeth or restorations; bone fractures; and possible involvement of the nerve that could result in a usually temporary, but possibly permanent, numbness or tingling in the lower lip.

I agree to abide by the doctor's post-operative instructions and that my failure to properly care for my oral health may lead to further complications.

Signed: ________________________________________ Date: ___________________

Relationship (to minor): _________________________________________________________

Witness (to signature only): ______________________________________________________

I acknowledge the receipt of, and understand my post-operative instructions.

Patient's initials: __________________________________

Patient's Name: __________________________________ Age: _______

# CONSENT FOR ORAL SURGERY AND ANESTHESIA

I hereby consent to the oral surgery indicated on the exam form and/or any related therapeutic procedures that in the judgment of the doctors may be necessary for my well-being. The nature and purpose of the operation and the therapeutic alternatives have been explained to me. No guarantee has been made or implied as to the result or cure.

I also consent to the administration of general anaesthesia, or intravenous sedation, or local anesthesia and the taking of radiographs as indicated.

I have been informed of all probable complications of the oral surgery and the use of anesthetics and other drugs. These complications include swelling, discomfort, nausea, vomiting, infection, numbness of the lip, chin, tongue, or gum, bone fracture, drug reaction, inflammation of a vein, delayed healing, damage to teeth and restoration, bleeding and sinus involvement.

I also understand that I am not to operate a motor vehicle or hazardous device for a 24-hour period following surgery. Medication for pain, sleep or sedation may cause drowsiness; therefore, alcohol should be avoided when such medications are taken.

I acknowledge the receipt of and understand postoperative instructions and have been given an appointment to return.

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Signed: ____________________________________________________

Relation (if minor): ____________________________________________

Date: ______________________________________________________

Patient Name: _____________________________________ Date: ________________

Proposed Operation: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

This is my consent to the oral and maxillofacial surgery. I agree to the use of: (check one)

| | | | |
|---|---|---|---|
| ________ | local anesthesia | ________ | intravenous sedation |
| ________ | inhalation sedation | ________ | ambulatory general anesthesia |

There are possible complications of the surgery, drugs, and anesthesia. The more common complications are pain, infection, swelling, bleeding, or discoloration. There can also be pain or inflammation from injection into a vein. There is a possibility of injury to or stiffness of the facial muscles or the jaw. There is also the possibility of injury to adjacent teeth, restorations, or other tissues, referred pain to the ear, neck or head, nausea, vomiting, allergic reactions, bone fractures, and delayed healing. Sinus complications may also occur which might include an opening into the sinus from the mouth with the removal of upper teeth. Temporary or permanent numbness of the lip or tongue may occur following removal of lower teeth associated with these nerves.

Medications have the potential to cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol and other drugs. I agree not to operate any motor vehicle or hazardous machinery for a 24-hour period following the use of intravenous sedation. In addition, I understand that pain medication may also cause drowsiness, lack of awareness, and problems of coordination.

I understand I will receive appropriate post-operative instructions and will be given an appointment date to return for observation. There is no warranty or guarantee as to any result and/or cure. I understand that I can ask any questions regarding the procedure including a detailed explanation of the complications.

____________ ____________________________________________

Date (Signature of patient or person with authority to consent for patient)

____________ ____________________________________________

Date (Witness)

**INFORMED CONSENT TO PERFORM ORAL SURGERY**

I have been given a diagnosis based on the information gained by clinical exam of . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I have been advised that the consequences of not treating this condition include but are not limited to: infection, swelling, pain, periodontal disease, malocclusion, fracture of the jaw and/or loss of bone. Impacted wisdom teeth are subject to and responsible for infections, cysts and tumors, cavities, pressure damage and periodontal damage to normal teeth, gum, and bone. These complications may cause pain, destroy jawbone and teeth, and adversely affect overall health.

Alternative treatments include but are not limited to: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I, the undersigned, give permission and consent to perform the following procedure(s): . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
and understand that certain risks and consequences exist which include but are not limited to:

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1. Post-operatively I can expect some pain, swelling, discoloration of the face, and/or bleeding. Swelling may occur for several days after surgery. Recuperation may require several days at home.
2. Local anesthetic reactions may occur. Although rare, this could include numbness, swelling, pain, infection, abnormal reactions or allergy and may adversely affect health. If you desire intravenous sedation or general anesthetic, or for any other reason we will refer you to an oral surgeon.
3. Numbness may occur in the region of the surgery, gums, lip or tongue. This is usually a temporary condition, but cases may be permanent.
4. A dry socket (poor healing of the socket) may occur. A dry socket is painful and requires frequent treatment at the office.
5. Root tips sometimes break off in the bone and may be left to avoid extensive surgery. With upper teeth, the root tips sometimes expose or are pushed into the maxillary sinus.
6. Infection is uncommon but may occur. Antibiotics may be needed postoperatively.
7. Fracture of the bone may occur.
8. Damage to adjacent teeth or restorations may occur.
9. Temporomandibular joint dysfunction (the jaw joint may not function well) may occur.
10. Any complications will be treated here or you will be referred to the appropriate specialist if additional treatment is needed. Treatment may consist of physical therapy, antibiotics or other drugs, or additional surgery.

I am aware that the practice of dentistry is not an exact science, that the very nature of the treatment and my uniqueness as an individual require that no predictions can be made. I acknowledge that no guarantees have been made to me. I believe it is in my best interest to proceed with my chosen treatment, as opposed to any alternatives which may exist. I have had ample opportunity to ask any questions I might have and have had them answered to my satisfaction. I agree to abide by the doctor's post-operative instructions and that my failure to properly care for my oral health may lead to further complications. I have had the opportunity to discuss with the doctor my overall health and medical history. I accept the risks of subsequent harms, if any, in hopes of obtaining the desired beneficial results of this treatment.

The risks involved with anesthesia and the treatment itself have been fully explained to me and I do give my free and voluntary informed consent to the same.

__________________________________________________ ____________________
Signature of patient or person authorized to consent for patient Date

# PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

The listed behavior management techniques have been explained to me by Dr. _______________. Alternative techniques for treatment, if any, have also been explained to me as have the advantages and disadvantages of each.

I hereby authorize and direct Dr. _____________________ assisted by other dentists and/or dental auxiliaries of his choice to utilize the behavior management techniques listed on the reverse side of this form to assist in the provisions of the necessary dental treatment as indicated for examination, cleaning of the teeth, taking of x-rays and for treatment as indicated on the child's examination chart, as previously explained to me by Dr. _____________________ for ___________________________, my child or legal ward for whom I am empowered to consent, with the exception of . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . (if none, state so).

I hereby acknowledge that I have read and understand this consent form, that I have been given an opportunity to ask questions I may have, and that all questions about the behavior management techniques have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that I am free to withdraw my consent to treatment at any time and that this consent shall remain in effect until I chose to terminate it.

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Date ___________________________ Time _______________________AM/PM

Patient's name ____________________________________________________________________

Signature of parent of guardian ______________________________________________________

Relationship to patient ____________________________________________________________

Signature of witness ______________________________________________________________

I certify that I explained the above procedures and techniques to the parent of legal guardian before requesting their signature

Signature of dentist _________________________________ Date ____________________

# PEDIATRIC DENTISTRY INFORM ED CONSENT for PATIENT MANAGEMENT TECHNIQUES and ACKNOWLEDGMENT of RECEIPT of INFORMATION

State Law requires health professionals to provide their prospective patients with information regarding the treatment or procedures they are contemplating. State Law also requires us to obtain your consent for any specific dental treatment, procedures or techniques which might be considered to be of concern to the patient or parent. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child*s dental treatment after considering the risks, benefits and alte

Please read this form carefully and ask about anything you do not understand. We will be pleased to

It is our intent that all professional care delivered in our dental operatories shall be of the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity. resistive movements, refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist*s hands or the sharp dental instruments.

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Alt efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. ***Tell-show-do:*** The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with Instruments on a model or the child*s or dentist*s finger. Then the procedure Is performed In the child*s mouth as described. Praise is used to reinforce cooperative behavior.
2. ***Positive reinforcement:*** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.
3. ***Voice control:*** **The** attention of a disruptive child Is gained by changing the tone or increasing the volume of the dentist*s voice. Content of the conversation is less important than the abrupt or sudden nature of the command.
4. ***Mouth* prop:** A rubber or plastic device is placed in the child*s mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
5. ***Hand-over-mouth-exercise:*** The disruptive screaming child is told that a hand will be placed over the child*s mouth. When the hand is in place. the dentist speaks directly into the Child*s ear end tells the child that if the noise stops the hand will be removed. When the noise stops the hand is removed and the child is praised for cooperating. If the noise resumes the hand is again placed on the mouth and the exercise repeated.
6. ***Physical restraint by the dentist:*** The dentist restrains the child from movement by holding down the child*s hands or upper body, stabilizing the child*~ head between the dentist*s arm and body, or positioning the child firmly in the dental chair.
7. ***Physical restraint by the assistant:*** The assistant restrains the child from movement by holding the child*s hands, stabilizing the head, and/or controlling leg movements.
8. ***Papoose Boards and Pedi-Wraps:*** These are restraining devices for limiting the disruptive child*s movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in these devices and placed in a reclined dental chair.
9. ***Sedation:*** Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally, by injection or as a gas (nitrous oxide and oxygen). The child does not become unconscious. Your child will not be sedated without your being further informed and obtaining your specific consent for such procedure.
10. ***General anesthesia:*** The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given general anesthesia without your being further informed and obtaining your specific consent for such procedure.

# PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

The listed pediatric dentistry behavior management techniques have been explained to me. Alternative techniques for treatment, if any, have also been explained to me, as have the advantages and disadvantages of each.

I hereby authorize and direct Dr.(s) ________________________________ assisted by other dentists and/or dental auxiliaries of his/her choice, to utilize the behavior management techniques listed on the reverse side of this form to assist in the provision of the necessary dental treatment for my child or legal ward:________________________________ ______________________________________________, with the exception of (if none, state so): . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I hereby acknowledge that I have read and understand this consent, and that all questions about the behavior management techniques described have been answered in a satisfactory manner, and I further understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent shall remain in effect until terminated by me.

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Date: ________________________ Time: _______________________________

Patient's Name: ________________________________________________________________

Signature of Parent or Guardian: ___________________________________________________

Relationship to Patient: _________________________________________________________

Witness Signature: ______________________________________________________________

I certify that I explained the above procedures and techniques to the parent or legal guardian before requesting their signature.

Signature of Dentist: ____________________________________________________________

# CONSENT TO PERFORM PERIODONTAL CLEANING

I ____________________________________________________, the undersigned, have been informed that I have periodontal disease, and that this disease process has been explained to me and that I fully understand the following:

1. This disease has resulted in the loss the bone which normally supports the teeth.
2. To help prevent the further loss of bone around my teeth, I must prevent buildup of live bacteria called “bacterial plaque” on a daily basis and it is my responsibility to schedule the regular dental checkups and cleaning’s after treatment is complete.
3. The proposed treatment plan to arrest the effects of periodontal disease that has been explained to me and I understand that additional treatment may be needed later if further problems develop.
4. As a result of periodontal root planing and curettage:
    a. The gums will be more receded where cleaned, and portions of the roots will be exposed post-cleaning.
    b. The exposed roots will be more sensitive to hot, color and/or sweets. This problem usually corrects itself in about six months time. Occasionally, further treatment may be needed. On rare occasions, this condition persists no matter what is done.
    c. The exposed roots, being more porous, will stain more easily than the crowns of teeth.
    d. Food will collect more easily between the teeth after meals.
    e. The teeth may be more loose immediately after cleaning. This occasionally persists indefinitely on isolated teeth where more bone loss has taken place. Normally, the teeth will eventually be about as loose as they were pre-operatively.
    f. If significant bone loss has occurred around upper front teeth, speech may be slurred post-operatively. In more severe cases, an appliance may be needed to replace missing gum tissue around front teeth for esthetics and to correct this speech problem.
5. Failure to follow these recommended actions will most likely result in continued bone loss with probably periodontal abscesses and eventually, tooth loss.

6. After an appropriate healing period, the status of periodontal disease will be evaluated. At that time, referral to a periodontist for periodontal surgery may be indicated.
7. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me.

The risks involved in the administration of anesthetics, sedative agents and the surgery itself have been fully explained to me and I do give my free voluntary informed consent to the same.

_____________ ______________________________________________

Date Signature of Patient

INFORMATIONAL USE ONLY

**INFORMED CONSENT STATEMENT**
**PERIODONTAL DISEASE**

This information is to ensure you that you are aware of the existing periodontal disease (gum disease) and infection that is present in your mouth. It is to acknowledge that you have been informed of the existence of this disease and given a copy of the periodontal pocket charting. The consequence of non-treatment will result in a progression of this infection, and if it continues will generally result in eventual bone loss, loosening of teeth and often loss of teeth. This also acknowledges the fact that on this date at least two options for treatment were offered:

1. A non-surgical approach to periodontal disease in which you are a co-therapist

2. Referred to a periodontal specialist for a surgical approach to therapy, or other as deemed appropriate

INFORMATIONAL USE ONLY

________ I accept option 1, for which a fee of $ ___________ has been quoted and I accept responsibility for the same.

Date: __________ Signature of Patient: ________________________________

________ I prefer to be referred to a specialist for treatment.

Date: __________ Signature of Patient: ________________________________

________ I decline both options 1&2, and prefer to have only a basic cleaning of my teeth, knowing that cleaning by itself will not prevent advancement of my disease or correct the disease. I also understand the consequences being potential loss of bone and teeth due to non-treatment of the disease.

Date: __________ Signature of Patient: ________________________________

Date: __________ Signature of Witness: _______________________________

# INFORMED CONSENT STATEMENT
# FOR PERIODONTAL THERAPY

*Please read the following information carefully. Risks associated with your periodontal therapy are explained below. Please take the time you need to ask all your questions before you sign.*

Periodontal therapy can be required for a variety of reasons. These reasons include the persistence of periodontal pockets that make proper cleaning of the teeth and gums impossible, the presence of infection and the loss of bone support to the teeth. Periodontal therapy is performed to reduce or eliminate these pockets, remove unhealthy tissue and to thoroughly clean the root surfaces of the teeth. However, due to many factors such as advanced state of disease, lack of adequate home care, nutritional or hormonal factors, etc., your problem may persist or even worsen with time and teth could be lost in the future.

It is important that you are aware that the success of your periodontal therapy is largely dependent on you. You must follow the instructions for home care very closely to get a good result. You should expect increased sensitivity of the tooth roots to cold, heat or sweets. This normally decreases over time, but the intensity and duration of discomfort vary greatly from person to person. Please be assured that we will use the utmost care in performing this procedure and have every reason to expect success.

INFORMATIONAL USE ONLY

I have read the above and have discussed with the Doctor the risks and treatment options of periodontal therapy. I understand that dentistry is not an exact science and no guarantee can be made to me. I hereby give my permission to proceed with the periodontal therapy.

Fee: ____________________

______________ ______________________________________________

Date Signature of Patient

*Please read and sign the following if you wish to decline the recommended treatment.*

I have been warned of the consequences of refusing the periodontal therapy. I fully realize that this recommended treatment is needed. However, at this time, I cannot arrange for the needed treatment and release the Doctor and his/her staff completely of any responsibility for the resulting long-term ill effects.

______________ ______________________________________________

Date Signature of Patient

# POST-OPERATIVE ORAL SURGERY INSTRUCTIONS

Care of the mouth following a surgical procedure is essential in the healing process. There is a certain amount of swelling, discoloration, discomfort and bleeding which can be expected.

**BLEEDING:** Some bleeding and oozing is to be expected for several hours. Avoid spitting and use of a straw as they may provoke oozing. Keep firm pressure on the gauze pack for 30 minutes and then discard. If bleeding is more than slight, use sterile gauze or a moistened tea bag over the area and again apply firm pressure for 30 minutes.

**DISCOMFORT:** If prescription was given, use as directed. The prescription should be filled promptly and taken exactly as directed before the local anesthesia wears off. Do not take pain medication on an empty stomach as it may cause nausea. If prescription was not given, over-the-counter medications (aspirin, Tylenol or Advil) can be taken as directed.

**SWELLING:** Some degree of swelling is normal and can be minimized with the use of ice or cold packs applied to the face at the extraction site for 15-20 minutes and then removed for 15-20 minutes. This should only be done for the first 24 hours. Maximum swelling will occur about the second or third post-operative day and then slowly recede.

**DIET:** A soft or liquid diet is recommended for the first few days following surgery. Until local anesthesia (numbness) wears off, be careful chewing to prevent biting the numb area.

**CARE OF MOUTH:** Do not rinse your mouth for 24 hours after surgery. After 24 hours, begin gentle warm salt water rinses for one week and resume gentle brushing of remaining teeth. Avoid use of alcohol, smoking or carbonated drinks for 24-48 hours after surgery. This may interfere with clot formation and slow the healing process.

**NOTE:** Antibiotics may decrease the effectiveness of birth control medications. Additional methods of birth control should be used while on antibiotics.

If any problems arise or if you have any questions, do not hesitate to call our office anytime at __________________________.

INFORMATIONAL USE ONLY

# SPLINT TREATMENT

A splint, or mandibular orthopedic repositioner is a removable appliance worn over the teeth to passively reposition the lower jaw to its physiologically most stable position. This positioning is needed for those with temporal mandibular joint (TMJ) problems or those requiring extensive restorative dentistry, in order to plan and perform further treatment needs. For splint therapy to be successful, 24-hours a day wear is required with removal only to clean it and the teeth.

For those wearing a splint wearing TMJ conditions involving limited or compromised function and/or pain may be secondary to other processes. These include but are not limited to traumatic injury, disc displacement, degenerative joint disease, inflamation, infection, arthritis, developmental or congenital defect, malrelation of the arches of the teeth, or systemic disorders.

For those with TMJ problems, such as symptoms as headaches, stiff necks, ringing in the ears, popping and clicking noises in the joints, and clenching and grinding of the teeth, can be relieved. Due to the complexity of the joints, and in most cases the duration of the problem, there is no assurance that all symptoms will go away or improve. Therefore, splint therapy is not just treatment, but also a diagnostic tool for us to determine what is happening in the joints. Radiographs such as tomograms or arthrograms may be needed through the duration of splint therapy depending on the course of treatment. Also, cross referrals to other specialties such as orthodontia, oral surgery, physical therapy etc. may be needed depending on oral surgery, physical therapy etc. may be needed depending on symptom ology. The length of treatment with a splint can be as short as 1-2 months for a restorative patient to as long as 1-2 years for a TMJ patient. The average patient is 5-10 months in treatment.

Once splint therapy is completed and this stable mandibular position has been located, an extensive occlusal (bite) analysis must be performed in order to make the diagnosis of how we are going to make the teeth fit together in this new position and resulting in malocclusion. This fitting of the bite may involve which things as equilibration, (a very sophisticated bite adjustment), orthodontia, oral surgery, reconstructive dentistry or any combination thereof. The treatment needed will be based on what the occlusal analysis shows. At this time, and extensive consultation will occur to inform you of recommended post splint treatment needs. It is important the patient understand equilibration, orthodontia, surgery or reconstruction is a possibility for every splint patient. Also, it is impossible to predict what will be needed with any certainty until after the occlusal analysis. Therefore, any patient considering splint therapy should be prepared for any of these recommendations prior to starting treatment.

There are always some substantial risks and complications with any treatment. Some of these include but are not limited to:

1. Lack of improvement of worsening of pain & jaw dysfunction
2. Resultant malocclusion and/or limited jaw opening
3. Further degenerative changes in the TMJ
4. Decreased lower jaw motion.
5. Noises in the TMJ

The amount of the risks are dependent on the present condition of TMJ, the body's host, response, and environmental influence.

Due to the complexity and duration of the problem with the joint, there can never be any assurance that the joint will always be healthy after treatment. Final occlusal treatment gives us the best opportunity to keep the joint healthy but again will not ensure it. There are many environmental factors (such as stress and bruxism, but not limited to those) that have an effect on the health of the joint. Any bone changes in the joint and position of the meniscus is always a concern in treatment. Whenever possible, final occlusion treatment will be done with the meniscus in position over the head of the lower jaw. If it is know that the meniscus is or could be out of position, we will inform you, but on occasion it is possible that this may not be known. This can occur when the patient is comfortable and has no other signs or symptoms indicating it. Further diagnostic studies to determine this are invasive and may not be indicated. If the meniscus is out of position and the patient is comfortable, it will become the patients decision if final occlusal treatment should be proceeding with. If the meniscus is out of position, and the patient is not comfortable, further evaluation by other health professionals, including surgical evaluation, may be necessary.

We hope this narrative has provided you the information you need, but if you have ANY FURTHER QUESTIONS, PLEASE FEEL FREE TO ASK. Also, if you would like a list of patients undergoing or having undergone this treatment, we will be glad to provide it.

I hereby acknowledge that I have completely read the foregoing, HAVE DISCUSSED ANY QUESTIONS OR CONCERNS regarding my treatment and acknowledge I have received a copy of this form.

Signature ______________________________ Date ____________________

Witness ______________________________ Date ____________________

Dentist ______________________________ Date ____________________

INFORMATIONAL USE ONLY

# SURGICAL INFORMED CONSENT

I hereby give permission to Dr. ______________________ to treat me (or my dependent ______________) and authorize the following procedure or such additional procedures as are considered necessary on the basis of findings during the course of said procedure: ..........................................................................

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The following reasons are why the above named surgery is considered appropriate: ..............................

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The following alternative treatment methods have been explained to me: ..........................................

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INFORMATIONAL USE ONLY

I have also been advised as to the probable outcome if no treatment is provided for this condition.

I consent to the following anesthesia and/or medications to be given at the time of surgery:

1. Local anesthesia
2. Local anesthesia with nitrous oxide/oxygen
3. Local anesthesia with nitrous oxide/oxygen and intravenous sedation

I understand there are certain common inherent risks possibly associated with this surgery and anesthesia including but not limited to:

1. Drug reactions and side effects
2. Post-operative bleeding, swelling, bruising, pain and discomfort
3. Post-operative nausea, weakness and possibly loss of time from work or school
4. Post-operative infection, delayed healing, bone inflamation
5. Sinus involvement possibly requiring additional treatment or surgery
6. Nerve injury within the lower jaw resulting in temporary but possibly permanent numbness and/or tingling of the lower lip, gums, or jaw
7. Bone fracture
8. Bruising or inflamation at the site of the intravenous injection

I understand the risks of driving, operating hazardous equipment, and drinking alcohol while recovering from anesthesia and while taking prescribed pain medication. I have been given the opportunity to ask questions regarding this treatment to clarify by understanding.

I am aware that the practice of oral surgery in not an exact science and I acknowledge that no guarantees have been made to me with regard to the procedures listed above.

..........................................................................................................

Date (Signature of patient or person with authority to consent for patient)

..........................................................................................................

Date (Dentist)

..........................................................................................................

Date (Witness)

# INFORMED CONSENT FORM

The doctor has explained to me the problem that exists with my teeth, mouth, and/or jaws. I understand that the nature and purpose of the surgical procedure(s) indicated to me by the doctor have been clearly explained to me together with attendant debility which may include but not limited to pain and swelling, bruising, altered diet, and limitation of jaw function. I accept the possibility that unforseen conditions may arise during my treatment that require modification, addition or alteration of the planned procedure(s). I hereby request and authorize the doctor to render such other procedures he/she deems advisable, necessary and therapeutic. I understand that dental surgery is not an exact science and that no guarantees have been made or implied.

I give my consent to the indicated procedure(s) realizing that risks and consequences may follow even when the procedure(s) is performed with the utmost care, judgement and skill. Those risks and consequences may include but are not limited to the following:

INFORMATIONAL USE ONLY

1. Numbness of the lower lip, chin and/or tongue resulting from injury to nerves close to the surgical area, usually temporary but on rare occasions may be permanent.

2. Delayed healing with or without infection, and/or premature clot loss which may require secondary treatment.

3. Excessive bleeding which may require secondary procedure(s) to control; damage to adjacent teeth or fillings; leaving selected pieces of teeth root in the jaw; opening into the maxillary sinus and/or jaw fracture, booth of which may or may not require secondary procedure(s); bone chips following tooth removal which may require secondary care.

I agree to cooperate completely with the doctor while under his/her care realizing that any lack of same could contribute to less than optimum results. The doctor has made me fully aware of alternative treatment and/or the possible consequences of no treatment. I have had adequate opportunity to discuss my past medical and health history. I am fully aware of fee for services, the payment of which I accept as my responsibility and obligation.

By my signature, I certify that I have had adequate opportunity to read and understand the terms, words and inferences within the consent.

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Date (Patient/Guardian/Parent)

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Date (Witness)

I have explained the procedure(s), alternatives, and risks to the person whose signature is above.

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Date (Dentist)

# AUTHORIZATION AND CONSENT TO SURGERY AND DRUG ADMINISTRATION

I hereby authorize Dr. ______________________ and whomever he/she may designate as assistants to perform upon me the following operation and procedures:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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and if any unforeseen condition arises in the course of these designated operations or procedures calling, in his/her judgement, for procedures in addition to or different from those now contemplated, I further request and authorize them to do whatever they deem advisable.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In Endodontic surgery, the most common of these complications include leaving a small piece of root in the jaw if removal of the root would require extensive surgery, post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental fillings. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness of lip, chin and tongue), broken jaw, sinus exposure and swallowing or inhaling of instruments and fillings into lungs.

INFORMATIONAL USE ONLY

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drugs or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), heart stoppage, and inhaling of stomach contents into lungs.

I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.

I further realize that in spite of the possible complications, my contemplated surgery is necessary and is desired by me. I am further aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

A FULL AND COMPLETE explanation of surgery and anesthesia is available to me upon my request from the doctor.

_____________ ______________________________________________________

Date (Patient/Guardian/Parent)

_____________ ______________________________________________________

Date (Witness)

## SURGICAL INFORMED CONSENT

I hereby give permission to Dr. _________________________ to perform the following procedure or procedures for myself or my dependent (________________________________) and such additional procedures as are considered necessary on the basis of findings during the course of said procedure: _________________________________________________________.

The following alternative methods of treatment have been explained to me as being practical and possible, but I desire the treatment mentioned above: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I hereby certify that I fully understand this authorization for surgical treatment and the reasons why the above-named surgery is considered necessary. I have been given the opportunity to ask questions and have been given satisfactory answers.

INFORMATIONAL USE ONLY

I consent for the procedure(s) to be done with the following anesthesia and/or medications:

_____ Local anesthesia
_____ Local anesthesia with intravenous sedation
_____ Local anesthesia with nitrous oxide and oxygen
_____ General anesthesia

I understand that the administration of the anesthesia is to be applied by or under the direction of

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I also understand that the administration of medications and performance of surgery carry certain common inherent risks, such as, but not limited to:

1. Drug reactions and side effects
2. Post-operative bleeding
3. Post-operative infection or bone inflammation
4. Possible involvement of the sinus of the upper jaw during removal of upper back teeth, requiring possible surgery for repair at a future date.
5. Possible involvement of the nerve within the lower jaw during removal of lower wisdom teeth, resulting in usually temporary, but possibly permanent numbness and/or tingling in the lower lip, right and/or left sides
6. Possible fracture of the lower jaw during the procedure
7. Bruising and/or vein inflammation at the site of the intravenous injections

I am aware that the practice of Oral and Maxillofacial surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of the procedures authorized above.

| ______________________________ | ______________________________ |
|---|---|
| Print Last Name, First Name, Middle Initial | Signature |
| ______________________________ | ______________________________ |
| Date | Witness |

# LIABILITY WAIVER

On ___________________________, 19___ in the course of a dental examination performed by Dr. _________________________________, I was informed of the need for necessary diagnostic x-rays. I have voluntarily elected not to have this diagnostic function performed. This is being done against the recommendation of the above named attending dentist. I do not hold the above named dentist liable for any failure to diagnose, or any misdiagnosis due to a lack of the recommended diagnostic x-rays. My reason for not permitting these x-rays to be taken is

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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I assume full responsibility for any conditions relating to my dental health that may have been diagnosed had the recommended x-rays been taken.

INFORMATIONAL USE ONLY

__________________________________________ ____________________

Signature Date

## X-RAY CONSENT WITHHELD

This will serve to document that I have refused to allow Dr. ___________________ to take radiographs (x-rays) of my teeth for the purpose of diagnosis.  I have had explained to me that my care would benefit from having x-rays taken and I understand the risks to my health of not having the x-rays taken.

INFORMATIONAL USE ONLY

_________________________________________ ___________________

Patient’s Signature Date

## RADIOGRAPH WAIVER

I, _____________________________________________ request that the following proposed radiograph(s): . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . not be taken, even though such examination has been recommended by my doctor, and in so doing, hereby release Dr. ____________________________________ from any responsibility for diagnosis which should have been made after such radiographic examination had been completed.

INFORMATIONAL USE ONLY

Patient: ______________________________________ Date: _____________

Witness: __________________________________________________________