

General Consent Form

Patient name: _____

Please read this form before you sign it.

Medical History Information

Please understand that it is important that you give all information about your medical history to your provider. It is important that you inform us of any medicines that you are taking each time that you come to an appointment, as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or with other medications. Please be sure to provide us with a list of any allergies.

Restorations (Fillings and Crowns)

I understand that care must be exercised in chewing on fillings and crowns until directed by the doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay or the condition of remaining tooth structure. I understand that sensitivity may occur after a newly placed filling or crown. I also have been informed that in some cases, root canal treatment may be required following a restoration. I realize that a large filling may not be a good long term solution and may lead to tooth breakage that will require further treatment.

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 may be necessary following routine restorative procedures. Also, a filling may be extended to cover additional surfaces if deemed necessary due to decay or fractures not evident upon the original examination. I give my permission to the dentist to make any/all changes and additions as necessary after consultation.

Complications

Although rare, complications can occur from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of

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alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe. Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.

X-Rays and Photos

Modern digital dental x-ray equipment exposes patients to a very low dose of radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays that allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series of intra-oral x-rays and/or a panorex every 5 years. All patients will also receive bitewing x-rays every 1-2 years depending on overall dental risk. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

Specific Problem Examinations

In the event that a patient requests only a specific problem be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the diagnosis and/or treatment on an emergency basis. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

Requests for records/x-rays

By law we are required to keep a patient's original x-rays and record in this office. Original x-rays or records will NOT be released. The patient or a designated person may request copies of their x-rays or record. We require a minimum of 5 days' notice to copy x-rays or record.

Specialty Referral and/or Second Opinion

General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

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I hereby authorize the dental staff of Richland Dentistry to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to allow Richland Dentistry to take any necessary x-rays and perform an examination on me today.

Patient or Parent/Guardian

Signature: _____

Date: _____

Doctor

Signature: _____

Date: _____

Witness

Signature: _____

Date: _____