

**North Summit Dental Care**

**Informed Consent of Dental Treatment**

**Dentistry to be Performed:**

 I consent to allow the doctor and/or clinical staff to obtain all necessary diagnostic information, such as radiographs (x-rays), as needed in order to reach a diagnosis of my condition. I understand that the doctor will visually examine my mouth and I will be asked to review all benefits, pertinent risks and alternatives to proposed treatment. My financial responsibility will be identified and I acknowledge that it will be my responsibility to pay these fees when treatment is started. My signature on the treatment plan will be an acknowledgement that all of this information has been presented to me, that I understand the proposal and that I consent to start treatment as listed.

 Initials

**Changes During Treatment:**

 I understand that during treatment it may be necessary to change or add procedures because of conditions which were not evident during the initial examination. If such a change or addition should occur the doctor will discuss the benefits, pertinent risks and alternatives, then ask for my initials or signature and date as consent of the changes prior to continuing.

 Initials

**Anesthesia or Medication:**

 I understand that I may require injections of local anesthesia, the use of nitrous oxide or may be prescribed antibiotics and/or analgesics. These medications can cause unusual or allergic reactions, including, but not limited to: nausea, swelling, pain, itching, tissue irritation, respiratory problems, prolonged muscle soreness, prolonged numbness of the lips or tongue, accidental tongue or lip biting while numb, or drowsiness. If I suffer any of these symptoms I will contact the doctor immediately for evaluation of my symptoms. I do voluntarily assume the possible hazards and risks as mentioned above and any possible side effects not mentioned and do agree to hold harmless North Summit Dental Care the doctors and staff.

 Initials

**Basic Restorations (Fillings):**

 I understand that North Summit Dental Care does not use or offer the silver amalgam material for restorations. I understand that if my insurance carrier provides a lesser alternate benefit for silver amalgam restorations, I will be responsible for the difference between the silver amalgam and the composite resin (white, tooth colored material) restoration fee.

 Initials

**Crowns, Bridges and Cosmetic Procedures:**

 I understand that I will be wearing a temporary crown, which may come off easily and that I must be careful to ensure that it is kept on until the permanent crown is cemented. I will be shown the final restoration before it is permanently installed. If I wish any changes, I must inform the doctor prior to cementation or give consent for the permanent cementation of the restoration. If I choose porcelain or bonded acrylic restorations, which are subject to chewing force, I understand that the restoration may fracture when I chew or it may prematurely wear down my opposing teeth and that North Summit Dental Care will not be responsible for any of these consequences and it will be my responsibility to pay additionally for any required subsequent services. I understand that once I have accepted the final restoration, and the doctor has permanently cemented it, any further changes or replacement will be at an additional expense. I understand that the potential complications include, but are not limited: tooth nerve death which would necessitate root canal treatment or tooth extraction, recession of the gum tissue surrounding the tooth which may create an adverse cosmetic result, and the inability to match the color or shape of the adjacent or opposing natural teeth.

 Initials

**Periodontal (Gum) Disease and Treatment:**

 I have been informed that I have active periodontal disease or that a previous episode of gum disease has weakened the supporting structure around my teeth. The doctor and/or hygienist has explained the methods of treatment, which include scaling and root planning with periodic follow-ups in this office or referral to a specialist for evaluation and treatment. I understand that there is no guarantee that this condition will be cured or that the affected teeth will be saved. I understand that treatment may take multiple appointments, may require the administration of local anesthetic and may cause post-operative root sensitivity, pain, bleeding, swelling, secondary infection, cosmetic disfigurement of the gum profile or other complications. I have the option to decline any treatment of my condition, but by doing so, I understand that my periodontal health will most likely worsen and could cause serious infection and the loss of teeth. Periodontal disease, when left untreated, may compromise the results of prior treatment, interfere with proposed treatment and possibly cause other health problems such as heart disease.

 I refuse active treatment. Initials

 I consent to treatment Initials

**Endodontic Treatment (Root Canal Therapy):**

 If I select root canal therapy as an alternative to extraction, I understand that there is no guarantee that the treatment will save my tooth or eliminate the infection. I understand the failure to keep the sequence of appointments necessary may cause the infection to worsen and reduce the chance of success. Complications of root canal treatment include, but are not limited to: incomplete filing due to canal curvature, broken filing instruments during treatment and damage to existing restorations during treatment. Some of these complications are beyond the control of the doctor and may lead to failure of the treatment and/or loss of the tooth. Additionally, recurrent infections may occur months or even years after the initial treatment and may require additional treatment of the tooth.

 Initials

**Extraction of Teeth or Other Oral Surgery:**

 I understand that removing the teeth does not always remove the infection, if present, and it may be necessary to have further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. I understand that the risks in having teeth extracted include, but are not limited to: pain, bleeding, swelling, secondary infection, dry sockets, temporary or possibly permanent numbness of the jaw, lips or tongue, complications involving the sinus cavities, adjacent teeth or other structures, muscle or joint irritation and soreness, or fracture of the jaw. I understand that if I refuse or delay the removal of the proposed teeth or other surgical procedure, that there is the potential for a worsening of my condition or development of a serious infection which could be life threatening. Alternative treatments to the removal of teeth, if indicated, such as root canal therapy or periodontal surgery have been explained to me and by consenting to extraction, I reject these options.

 Initials

**Dentures (Complete or Partial):**

 I understand that complete or partial dentures are artificial and constructed of plastic, metal and/or porcelain. The difficulty of wearing these appliances has been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes to my new denture, including shape, size, fit, placement, and color, will be the "teeth in wax" try-in appointment. I understand that most dentures require relining (adjustment) approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

 Initials

I do affirm that I speak and comprehend English, acknowledge that I have read and fully understand the above Informed Consent of Dental Treatment, and that the explanations there in referred to were made and fully understood. I do voluntarily assume the possible hazards and risks as mentioned above and any possible side effects not mentioned and do agree to hold harmless North Summit Dental Care, the doctors and staff. I also agree to allow North Summit Dental Care to disclose necessary information to my insurance company to get claims paid. If I chose to decline to have information disclosed to my insurance carrier I understand that insurance may deny payment of some claims, if this should happen, I understand that I will be responsible for any further balance on my account.

Patient/Guardian Signature: Date:

Attending Doctor Signature: Date:

Witness Signature: