UNDERSTAND AND CONSENT (TO YOUR DENTAL TREATMENT)

FOR _____

Significant improvement in health, appearance and speech is most frequently achieved in the vast majority: of dental patients. But like any other treatment of the body, dental procedures (restorative, periodontal, orthodontic, surgical, endodontic or prosthodontic) have some inherent risks and limitations. These are seldom that serious as to contra-indicate the dental treatment recommended, but should be considered in making the decision to proceed with treatment. You are therefore urged to read the following information, ask us any questions that my come to mind, then (after you are completely satisfied with our explanations) consent to our treating you or your relative by signing this form. This is now a standard procedure in our office.

1. I have discussed my* medical and dental history with the doctor and have informed him of all allergies, and other serious problems that troubled me*. He has informed me of my present dental health and condition. 2. I understand the problem(s) that exist in my mouth. 3. I understand the doctor's treatment plan(s) and the procedure(s) involved: and the consequences of full, partial, or not treatment and the risks involved in proceeding with treatment and those risks involved in my refusing treatment. 4. The Treatment Plan which will benefit me the most was explained as well as alternative procedures. 5. I understand the purpose of treatment and the benefits we hope to achieve. I also understand that no one can predict the certainty of our treatment's result and I realize that I may be disappointed and that treatment might even be regarded as a failure in that condition could possibly worsen or that treatment would not satisfy my dentist's or my expectations. There is no guarantee of success, but of course it is our goal. 6. The fees associated with each treatment option were presented to me and fee payment schedules were discussed. 7. My responsibilities include making and keeping appointment on time, caring for my teeth and gums before, during and after treatment, following all other instructions given me and completing all financial obligations incurred. 8. I understand also that an unpredictable situation may occur during the doctor's treatment procedures and, within reason, do consent to any unspecified treatment the dentist deems necessary resulting from such unforeseen circumstances arising. 9. I realize that I need not consent to all these recommended treatment procedures and I have a right to alter this form accordingly within reason. 10. I have had the opportunity to ask any questions about my proposed treatment, and all questions have been answered to my complete satisfaction.

***If you are the patient's parents, the words "my" or "me" should be substituted with the words "the parents" or "the patient" respectively.**

The RISKS of course depend upon dental procedures involved. These procedures may include restorative dentistry, periodontal treatment, orthodontic therapy, surgery, endodontic and prosthodontic treatment as well as minimal exposure to X-Rays for necessary diagnostic purposes.

These risks may include: bad breath, tooth sensitivity to hot and/or cold, undesirable tooth movements, tissue inflammation and infection tooth mobility gum and bone recession, pain, swelling, bleeding, premature tooth loss, worsening of a periodontal condition, chewing or speech difficulty, oral opening restrictions,_____ pain disorder, unanticipated pulp chamber exposure necessitating pulp capping or tooth _____ requiring root canal therapy and all the risks involved therewith; unpredictable surgery and all its risks, possibly including tissue sloughing, implant rejection or an unanticipated apico-ectomy: an unpredictable procedure requiring local or general anesthesia and all the risks involved therewith.

Again, it is our intent to inform you of the myriad of possibilities that exist as potential problems. Most of these conditions would rarely occur. There may he other inherent risks not mentioned. You should be aware that these things can happen. If any of these conditions should develop, every effort will be made to properly treat the patient or refer him or her to the appropriate dentist or physician. Treatment of human biologic condition will never reach a state of perfection despite technological advancements. Your treatment depends on a close professional working relationship. Patients and their relatives should feel free to inquire about an aspect of their treatment. Understanding and cooperation are essential for the results we both seek.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORMAN D UNDERSTAND THE AUTHORIZATION THAT I AM ABOUT TO SIGN FOR PROPOSED TREATMENT, MEDICATION OR SURGERY DESCRIBED TO ME. I REALIZE AND ACCEPT THE RISKS OF SUBSTANTIAL HARM, IF ANY, AND THE LIMITATIONS INVOLVED IN THE HOPE OF OBTAINING THE DESIRED BENEFICIAL RESULTS, AND DO CONSENT TO MY DENTIST'S TREATMENT PLAN.

_____ _____

Signature of Patient, Parent, Guardian Date