FAMILY CARE DENTISTRY INFORMED CONSENT

DRUGS AND MEDICATIONS: I understand that analgesics, anesthetics, and other medications can cause allergic reactions resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe reactions. I have informed the doctor and/or staff of any known allergies. Certain medication may cause drowsiness and it is advisable not to drive or operate machinery when using such drugs.

RISKS OF ANESTHESIA: I understand that pain, bruising, and occasional temporary and sometimes permanent numbness in the lips, cheeks, tongue and associated facial structure can occur with injections ("shots"). About 90% of these cases resolve themselves in less than 8 weeks. Although rarely needed, a referral to a specialist for evaluation and possible treatment may be needed of the symptoms do not resolve and any costs thus incurred are my responsibility.

FILLINGS: I understand that a more extensive restoration than originally planned, or possibly root canal therapy may be required if additional conditions are discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

CROWNS, BRIDGES, INLAYS & ONLAYS: I understand that sometimes it is not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify the office of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc of a crown must be made prior to final fabrication and cementation. It is my responsibility to return to the office for final cementation of the restoration. I understand I may need further treatment and even by a specialist if complications arise during treatment and any costs thus incurred are my responsibility.

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

CHANGES OF TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. The doctor and/or staff will discuss with me and I authorize my doctor to use professional judgment to provide appropriate care.

REFERRALS: I understand that it is sometimes necessary for me to be referred to a specialist or other healthcare provider in the event my healthcare would be better served elsewhere. I understand that I would be subject to the fees incurred by the referred provider and that it is my responsibility to speak with the provider to which I have been referred regarding their fees or my financial responsibilities.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantee have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all of my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Signature: **Date:**