PATIENT CONSENT FORM

In reading and signing this form, it is understood that ENGLISH is the language that I understand and use to communicate.

☐ **1. DRUGS, MEDICATION AND ANESTHESIA:**

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four [24] hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloral hydrate, "Xanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation and that someone needs to watch me closely for a period of 8 to 10 hrs.

(Initials)_____

☐ **2. ORAL HYGIENE**

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

(Initials)_____

☐ **3. PERIODONTICS (TISSUE AND BONE LOSS)**

I understand the serious condition of periodontal disease causing gum inflammation, bone inflammation, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

(Initials)_____

☐ **4. REMOVAL OF TEETH:**

I understand that the purpose of the procedure/surgery is to treat and possibly correct diseased oral tissues. If this condition persists without treatment or surgery, the present oral condition will probably worsen in time.

Potential risks include, but are not limited to, the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e., surgery.

B. Injury to adjacent teeth, caps, or fillings (requiring the re-cementation of crowns, replacement of fillings. fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.

C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty possibly requiring physical therapy or surgery).

D. Residual root fragments or bone spicules left when complete removal should require extensive surgery or needless surgical complications.

E. Possible bone fracture which may require wiring or surgical treatment.

F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning sensation of the lip, chin, gums, cheek, teeth, and/or tongue or pain in the jaw on the operated side; this may persist for several weeks, months, or in remote instances, permanently.

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

(Initials)_____

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(Initials)_____

☐ **5. FILLINGS:**

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and as such is a treatment used by Universal Care. The advantages and disadvantages of alternate materials.

(Initials)_____

☐ **6. CROWN AND BRIDGE (CAPS)**:

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(Initials)_____

☐ **7. DENTURES - COMPLETE OR PARTIAL:**

The problems of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

(Initials)_____

☐ **8. ENDODONTIC TREATMENT (ROOT CANAL THERAPY):**

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that treatment risks can include, but are not limited to the following:

- **A**. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary.
- **B**. Post treatment swelling of the gum area in the vicinity of the treatment tooth or facial swelling, may persist several days or longer.
- **C**. Infection and/or restricted jaw opening.
- **D**. Breakage of root canal instruments during treatment, which may in the judgment of the doctor be left in the treatment root canal as part of the filling material; or it may require surgery for removal.
- **E**. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
- **F**. Risk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss. If root canal therapy fails, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

(**Initials**)_____

☐ **9. PEDIATRIC DENTAL CONSENT FORM:**

I understand that the following procedures are routinely used at Universal Care Dental Services, as well as being accepted procedures in the dental profession.

- **A. Parent/guardian Cooperation -** Unless the child is fully cooperative in the presence of the parent/guardian, the parent/guardian agrees to remain in the waiting room while the child is being treated.
- **B. Positive Reinforcement -** Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
- **C. Voice Control** - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite his/her lip causing injury to occur. I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

(Initials)_____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE COOPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT UNIVERSAL DENTAL CARE PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

_____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date

_____ _____

Signature of Doctor | Dr. No.