General Informed Consent
&
Office Policy

1._____Examination and Radiographs- I understand that the initial visit, as well as some periodic exams, will require radiographs and intraoralcamera images in order to complete the examination, diagnosis, and treatment plan.

2._____Dental Prophylaxis (cleaning)- I understand that if a preventive cleaning is performed, the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. I understand bleeding could last several hours. If bleeding persists, particularly if it is severe in nature, immediate attention is required and the office must be contacted.

3._____Drugs, Medication, and Sedation- I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any and all known allergies. Also, the drugs, medication, and sedation may cause drowsiness, lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication, and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain with potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

4._____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, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any and all changes and additions as neeeded.

5._____Temporomandibular Joint Dysfunction (TMD)- I understand that popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

6._____Dental Benefits- I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance is done as a courtesy and full payment is ultimately my responsibility. I understand that my insurance may have waiting periods, frequency limitations, or other clauses that would alter my estimated portion. I elect to follow the Dentist recommendations of optimal dental treatment.

Patient (please print)_____
Signature_____ Date_____