Gentle Care Family Dentistry At Stanford Ranch

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Informed Consent

WORK TO BE DONE: I understand that the following treatments may be performed on me as part of my dental treatments. Fillings, bridges, crowns, extractions, impacted tooth removal, root canals, dentures, partial dentures, periodontal treatments and possible other dental work.

FILLINGS: Fillings are procedures in which the dentist removes decayed tooth structure or a faulty restoration and replaces it with composite or silver amalgam fillings. I understand that these procedures could cause the teeth to be sensitive to hot and cold as well as chewing. The majority of the times, these sensitivities are temporary and they will go away within one or two weeks. However, there are times that due to the depth of the filling of the tooth, the pulp or the nerve of the tooth becomes irreversibly sensitive. In these cases, the tooth will need to be treated for a root canal therapy and might possibly require a post and a crown to be fully restored. I understand that the dentist cannot guarantee that the teeth receiving fillings will not need to receive the above mentioned additional procedures and that I will be responsible for payments for any additional treatments needed to restore the teeth, if the initial filling does not correct the problem.

DRUG AND MEDICATION: I understand that antibiotics, analgesics, and other medication can cause allergic reactions causing redness and swelling of tissue, pain, vomiting, and anaphylactic shock (severe allergic reaction.)

REMOVAL OF TEETH: alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth outlined in the treatment plan. I understand removing teeth does not always remove all infections, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parathsia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

ANESTHESIA: I realize the risk involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage, and numbness.

DENTURES – COMPLETE OR PARTIAL: I realize that full or partial dentures are artificial, constructed of plastic, metal or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, possible breakage, and relining due to tissue and bone change.

CROWNS, BRIDGES, AND VENEERS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered, and that if I do not have the permanent crown(s) placed, permanent serious damage or loss of the tooth/teeth involved may ensure, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

PERIODONTAL LOSS (TISSUE AND BONE): I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth.

I hereby request and authorize the Dentist, and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me. I also authorize the operating dentist assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infections, hemorrhage or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues, fractured jaw, which could cause localized and systemic pain requiring future treatments including joint surgery, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLAINATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature of Patient _____ **Date** _____

Witness _____ **Date** _____

Doctor _____ **Date** _____