

J. Bradford Smith, D.D.S. Cosmetic and Family Dentistry

ADULT CONSENT FOR DENTAL PROCEDURES

It is customary of our office to inform patients of all procedures contemplated. At each examination appointment, we will identify any dental treatment needed and describe this to you. We follow recommendations made by the American Dental Association instead of insurance limitations. Each routine examination visit consists of oral hygiene instructions, cleaning of the teeth, topical applications of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment such as sealants, fillings, crowns, bridges, implants, occlusal guards, etc., will be performed at a separate appointment after obtaining your permission.

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 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 or all changes and additions to the treatment plan as necessary.

Drug and Medications: I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand this and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any anesthetic medication or drugs that may be given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Extractions: Alternatives to removal of teeth have been explained to me (root canal therapy, crown and bridge procedures, periodontal therapy, etc.) I understand removing teeth does not always remove the infection, if present, and may be necessary to have further treatment. I understand the risks 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 (paresthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Crowns, Bridges, 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 come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. It is also my responsibility to return for **permanent cementation within 60 days from tooth preparation**. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be *additional charges for re-makes due to my delaying permanent cementation*.

Fillings: I understand that care must be exercised in chewing on filling teeth, especially during the first 24 hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decays. I understand that significant sensitivity is a common after effect of newly placed fillings.

Periodontal Treatment: I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand that treatment plans (non-surgical cleaning, gum surgery and/or extractions) may vary depending on the severity of the periodontal conditions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

Partials and Dentures: I understand the wearing of partials/dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed at a later date. This is **not** included in the denture fee. I understand that it is my responsibility to return for delivery of my partial/denture. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. *If a re-make is required due to my delays of delivery of more than 60 days, I understand that additional lab charges could be incurred.*

Occlusal Guards: I understand that an occlusal guard may minimize the possible harmful effects of occlusal habits including: sensitive teeth, worn teeth, cracked or fractured teeth. I also understand that the occlusal guard will not prevent my occlusal habits from continuing but rather introduce a protective material between my upper and lower teeth to minimize additional damage or symptoms of occlusal stress. It is only effective while it is being worn and provides no protection during times when it is not worn. I have been informed that my condition can sometimes be treated simply over the short term or could require treatment over several years and could include orthodontic treatment, restoration with crowns, bridges, implants or surgery. *If a re-make is required due to my delays of delivery of more than 60 days, I understand that additional lab charges could be incurred.*

Longevity/replacement. The occlusal guard will/may require replacement if it is lost, damaged, worn or the underlying teeth are changed (with new fillings, crowns, bridge, etc.). Additional fees will apply if replacement is necessary.

Acknowledgment: I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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. For example, root canal therapy following routine restorative procedures.

Patient Signature _____ Date _____ Office Staff _____ Date _____