BEST NATURAL smile™
AESTHETIC & RESTORATIVE DENTISTRY

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TREATMENT TO BE PREFORMED AND GENERAL DENTISTRY CONSENT FORM

I understand that I am having the following treatment and acknowledge the important information below:

1) DENTAL X RAYS: I understand that it is necessary to take bitewing and/or periapical dental x-rays for dental diagnosis as recommended by my treating Dentist. Though dental x-ray exposure is minimal, every effort to reduce my exposure has been taken with the use of a lead apron and thyroid collar. I understand that cumulative exposure to x-ray is potentially harmful.

If I am pregnant or may be pregnant, I have advised my Dentist and any members of his/her staff involved in x-ray procedures. X-rays will be taken as the dentist deems necessary and by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their offices.

INITIAL_____DATE_____

2) DENTAL SCALING: (Also known as: gross debridement, deep scaling, deep cleaning, quadrant scalings, dental scalings, periodontal maintenance scalings, and dental prophylaxis). These procedures are to clean and/or aid in rehabilitation of the gums, teeth and underlying bony structures. Periodontal disease is often chronic and a symptomatic. Upon completion of, or during these procedures, I may have sensitive gums or teeth, especially around the interface between the teeth and gums. Often, gum line sensitivity is noticed for a few hours to several days after these procedures. Occasionally, soft tissue or gum swelling may occur. Should any of these conditions arise and not subside within a few days of these procedures, I will contact my treating Dentist for advice and potential follow up treatment. Sometimes these procedures uncover dental conditions, which were not readily apparent at an initial exam. These procedures are often part of the diagnostic procedure to determine dental conditions I may have. These procedures will be prescribed as the Dentist deems necessary and by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their offices.

INITIAL_____DATE_____

3. FILLINGS AND OR BONDING PROCEDURES: I understand that care must be exercised in chewing on Fillings or Bonding Procedures, especially during the first 24hours to avoid breakage. I understand that a more extensive Filling or Bonding Procedure than originally diagnosed may be required due to additional findings. This may include the need to place a crown or other restoration instead of a Filling or Bonding Procedure. I understand that it is not always possible to match the color of natural teeth or adjacent teeth with Fillings or Bonding Procedures. As these procedures have been advised by my treating Dentist, by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their offices.

INITIAL_____DATE_____

4. CROWNS AND OR BRIDGES: I understand that it is not always possible to match the color of natural teeth or adjacent teeth with Crowns/Bridges. I further understand that I may be wearing temporary Crowns/Bridges, which may come off and that I must be careful to ensure that they are kept on until the permanent Crowns/Bridges are PERMANENTLY cemented. I understand that I must have the permanent Crowns/Bridges cemented permanently within one month of the beginning of their preparation. If I do not, I accept responsibility for additional procedures resulting from my delay, including but not limited to: Root canal therapy and/or replacement of my crowns/bridges as they may not fit or can re-decay. I realize that the final opportunity to make changes in my new Crown(s)/Bridge(s) (including shape, fit, size, and color) will be BEFORE PERMANENT CEMENTATION. As these procedures have been advised by my treating Dentist, by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their offices.

INITIAL_____DATE_____

5. POST FABRICATION/POST PLACEMENT AND OR BUILDUP: Posts are an attempt to aid in holding a crown or bridge type restoration. Posts can fail to hold the crown or bridge type restoration. Posts can bend or break. This is unpredictable. Any procedures involving posts or buildups are a last chance attempt to save the tooth or teeth involved in supporting a crown or bridge. These teeth are more vulnerable to fracture by having this procedure, which could cause their being lost, and requiring additional treatment and costs to me. Fractures can occur during the procedure or present themselves at any time post-operatively. Fractures can exist before post placement, which are undetectable. If these types of fractures present themselves by symptoms or clinical findings, the tooth may be lost. This eventuality would necessitate additional treatment and costs to me.

As these procedures have been advised by my treating Dentist, by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their offices.

INITIAL_____DATE_____

6. DENTURES AND PARTIAL DENTURES: I understand the wearing of dentures or partial dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. **Immediate Dentures** (placement of denture(s) immediately after extractions) may be painful. Any denture may require considerable adjusting and several relines. A permanent reline will be needed within several months of initial placement of any denture or partial denture, especially where the extraction of teeth was involved. This is NOT included in the denture/partial denture fee. I understand that it is my responsibility to return for delivery of denture(s)/partial denture(s). I understand that failure to keep my delivery appointment may result in poorly fitted denture(s)/partial denture(s). If a remake is required due to my delay of more than 30 days, there will be additional charges. As these procedures have been advised by my treating Dentist, by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their offices.

INITIAL_____DATE_____

7. ANY DENTAL PROCEDURE INVOLVING FILLINGS, BONDING PROCEDURES, CROWNS OR BRIDGES MAY RESULT IN SIGNIFICANT POST-OPERATIVE SENSITIVITY: This may require the need for root canal treatment or other additional procedures. This treatment has additional costs and procedures, which have been explained to me. In some cases, Fillings or Bonding Procedures may become too large and require a crown or other restoration. As dental procedures have been advised by my treating Dentist, by initialing and/or signing this statement, I give my treating Dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their offices.

INITIAL_____DATE_____

8. LOCAL ANESTHETICS, ANTIBIOTICS OR ANALGESICS (PAIN RELIEF MEDICATIONS):

I Understand that the use of these medications can cause redness, swelling, soreness, pain, itching, vomiting, increase in heart rate and other specific or nonspecific reactions. If I have any concerns or questions, my treating Dentist has answered them.

We sincerely hope that you will value our strong dedication and commitment to providing you with a lifelong beautiful smile.

I have read and understand the office policy described above.

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Patient Signature Date