General Dentistry Informed Consent for Services

WORK TO BE DONE
I understand that I may be having the following work done: Exam, X-rays, Prophy/Cleaning, and Fillings. This consent will be valid indefinitely or unless otherwise expressed in writing by the physician or the patient.

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 the examination. For example, root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions necessary.

PERIODONTAL CLEANING/SCALING
I understand that most common complications are pain, bleeding, tissue (gum) laceration, sensitivity to temperature or foods, swelling, ulceration (infection), tooth fracture, and/or breaking of fillings. Reactions to fluoride treatment may be nausea or vomiting.

FILLINGS
I understand that the most common complications are pain, sensitivity to temperature, fracture of tooth, nerve damage, damage to other teeth, occlusal (bite) discrepancies, TMJ complications, reactions to drugs and/or anesthesia. Sensitivity to hot and cold temperatures could last for a long time after the work is done. Most of the time it is just a few days. There could also be tenderness to bite and the bite may need to be adjusted.

The doctor has explained to me that there are certain inherent and potential risks in ANY treatment plan or procedure. We do not expect these to occur, but there is that possibility. In this specific instance such as risks included, but not limited to the following:

A. Nerve inflammation leading to hot and cold sensitivity due to deep decay or extensive restoration.
B. The need for endodontic therapy (root canal therapy).
C. Cracked cusp and/or fracture of the tooth or filling.
D. A shorter length of serviceability of the restoration with the need for more frequent replacement.
E. In cases where the previous restorations (fillings) are very large, the use of cast or full coverage crowns, or bonded porcelain may be indicated.

LOCAL ANESTHETIC
It has been explained to me that there are certain risks to having local anesthetic or "shots" with a needle. They include allergic reactions, electric shock, or possible death. I understand there can be numbness in my lip or tongue or chin that can last several weeks or permanent in rare cases. Further I realize that if epinephrine is used it can cause heart flutter and acute anxiety. Local anesthetic can cause drooping of the eyelid and side of the face known as Bell's Palsey effect. At the injection site there can be bruising, swelling, or a hematoma. Additionally, muscle soreness can occur on or at the injection site that can last several days or more.

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment with I have requested or authorized.

I hereby authorize Dr. Douglas B. Evans, DDS, MS, and his staff to proceed with and perform the dental procedures and treatments as had been explained to me. I understand this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Patient Name (Please Print):_____

Patient Signature: _____ Date: _____
(If under 18 yrs old, the parent or legal guardian)

Doctor: _____ Date: _____
Douglas B. Evans, DDS, MS

Witness: _____ Date: _____