



Informed Consent for Services

We are delighted to have you as a patient, and our goal is to provide thorough, quality dental care for you and your family. To uphold this high standard, this office performs the following routine dental procedures on all patients:

- ✓ Complimentary Oral Cancer Screening and Oral Hygiene Instructions at least once a year
- ✓ Panoramic radiograph for patients with adult dentition to be repeated at least every 5 years
- ✓ Periodic exams at least once a year
- ✓ Bitewing radiographs at least once a year for adults and twice a year for pediatric patients
- ✓ Fluoride treatment at least once a year for adults and twice a year for pediatric patients

These procedures may incur an extra fee. If you do not wish to receive any of the above procedures, please state below:

Please initial the following to confirm your understand and consent for the indicated procedure.

Initials _____ **EXAMINATIONS AND X-RAYS**

I understand that radiographs and exams are necessary in order to diagnose treatment and will be performed unless otherwise stated.

Initials _____ **DRUGS AND MEDICATIONS AND SEDATION**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions, redness, swelling, pain, itching, and/or anaphylactic shock. I understand that some medications may cause drowsiness and lack of coordination which can increase with use of alcoholic or other drugs. 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 the potential resistance to effective treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Initials _____ **CHANGES IN THE 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. I give my permission to the Dentist to make any/all changes and additions necessary to the treatment plan.

Initials _____ **CROWNS/ONLAYS/INLAYS, BRIDGES AND VENEERS**

I understand that necessary restorative procedures may require the removal of necessary tooth structure to place an adequate restoration. I understand that sometimes it's not possible to match the color of artificial teeth exactly to the natural teeth. I further understand that I may be wearing temporary crowns/fillings that may come off and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize that the final opportunity to make changes to my restoration (including shape, size, fit and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from the preparation date. 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 remakes due to me delaying permanent cementation.

Initials _____ **ENDODONTIC TREATMENT (ROOT CANAL)**

I understand that certain circumstances require the removal of pulpal tissue from the root canals of indicated teeth. I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that, occasionally, root canal filling materials may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments; stresses vented in their manufacturing can cause them to separate or break during use. I understand that a crown may be necessary following root canal treatment, and that a delay in receiving an indicated crown may result in fracture of the tooth or other damage which could result in loss of the tooth. I understand that sometimes additional surgical procedures may be necessary following root canal treatment. I understand that the tooth may be lost in spite of all efforts.

Initials _____ **PERIODONTAL TREATMENT**

I understand that periodontal disease is a serious, progressive infection causing gum inflammation and deterioration, bone loss, and can lead to the loss of teeth. I understand that after treatment, there can be tenderness, swelling, pain, sensitivity to temperature and/or bleeding. I understand alternative treatment is available, including gum surgery, replacements and extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. I understand the success of any treatment depends in part on my overall oral health and hygiene including efforts to brush and floss daily, follow maintenance schedules, and other recommendations.

Initials _____ **FILLINGS**

I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity is common with a newly placed filling. I understand that the most common complications are sensitivity to temperature, fracture of tooth, nerve damage to other teeth, bite discrepancies and TMJ complications.

Initials _____ **DENTURES AND PARTIALS**

I understand that wearing of dentures or partials may be difficult. Sore spots, altered speech and difficulty eating are common problems. Immediate dentures may be painful and may require considerable adjustments and several relines. I understand a permanent reline will be needed later and is not included in the denture fee. I understand that it is my responsibility to return for delivery of dentures and that failure to keep my delivery appointment may result if poorly fitting dentures or partials. If a remake is required due to my delay of more than 30 days, there will be an additional charge.

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 that I have requested and authorized. I hereby authorize Dr. Matthew Artho and his dental auxiliaries to proceed with the dental procedures/treatments as have been explained to me. I understand that treatment estimates are 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, collections, or court costs that may be incurred to satisfy this obligation.

Signature of Patient _____

Date _____