OnSite Dental Care of New England

GENERAL DENTISTRY INFORMED CONSENT FORM

1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. DRUGS, MEDICATION, AND SEDATION

I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). 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.

3. 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 additional decay on adjacent tooth. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. FILLINGS

I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

5. REMOVAL OF TEETH (EXTRACTION)

If there is any alternative to removal it has been explained to me. (I authorize the Dentist to remove the teeth outlined on treatment plan and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time.

6. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. Some of the problems associated with wearing those appliances include looseness, soreness, and possible breakage. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

7. PERIODONTAL TREATMENT

I understand periodontal disease is a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: I understand that dentistry is not an exact science, therefore: reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered. This consent is valid for one year from date signed.

_____ _____

Signature of Patient, Guardian, HCP or POA Date

_____ _____

Please print name of Patient, Guardian, HCP or POA Relationship to Patient