Premier Dental
Informed Consent

1. X-Rays and Examination
I understand I will be receiving a dental exam from a state licensed dentist. I understand that while X-rays are taken, I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive exam. Initials_____

2. Drugs, Medication, and Sedation
I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, 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 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 effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. Initials_____

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 the 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/all changes and additions as necessary. Initials_____

4. Temporomandibular Joint Dysfunction (TMD)
I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. Initials_____

5. Fillings
I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after-effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being placed. Initials_____

6. Removal of Teeth
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any other necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it 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 (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. Initials_____

7. Crowns, Bridges, Inlays, Onlays and Veneers
I understand that I may be wearing temporary crowns which must not be removed until the permanent crowns are delivered. I must return for permanent cementation within 20 days of tooth preparation. Extended delays between the time of tooth preparation and crown cementation may cause tooth movement, accumulation of bacteria, and/or infection of tooth structure and the surrounding tissues. It may then be necessary to redo the procedure, and in some cases, remove the teeth. I understand there will be additional charges for remakes due to my delaying permanent cementation. I also understand that after placement of a temporary or permanent crown, my tooth may be temporarily sore or uncomfortable. Occasionally the pulp (nerve tissue) may be irritated by the preparation process or from prior trauma or decay. This may make my tooth extremely sensitive. I understand that if persists, root canal therapy may be necessary at an additional charge. I also understand that in the event I have an existing partial denture and am having a crown placed on any tooth immediately adjacent to such, adjustments are not always successful. In the event that appropriate adjustment cannot be made, I acknowledge that after crown placement I may need a new partial denture at an additional charge. Initials_____

8. Root Canals/Endodontic Treatment
I understand there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment: root canal filling material can extend through the tooth (which will not necessarily affect the success of the treatment) and endodontic files and reamers can break during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment. Initials_____

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

10. Dentures and Partial Dentures
I understand wearing dentures is difficult. Looseness, soreness, altered speech, possible breakage, repeated adjustments, and eating difficulties are common. I realize the last chance to make changes will be the “teeth in wax” visit. I understand most dentures require relining after initial placement, which is not included in the initial denture fee. I understand that failure to keep my delivery appointment will result in poorly fitted dentures. If a remake is needed due to my delays of more than 1 month, I will incur additional fees. Initials_____

I understand that there are has been no guarantee or assurance made by anyone in regard to the dental treatment I have authorized. I also acknowledge that I am ultimately responsible for all dental fee payments regardless of any dental insurance coverage.

Signature of Patient_____Date_____

Signature of Doctor_____Date_____