INFORMED CONSENT FOR DENTAL TREATMENT

A. IDENTIFICATION

I,(Print Patient Name) _____request and authorize Dr. _____, Dental Hygienists, and Dental Assistants of **Aava Dental** to perform the following treatment/procedure(s):

B. STATEMENT OF REQUEST Please initial beside the following lines. By initialing, you signify you fully understand the statement and/or our office policies

_____ FOR ALL NEW PATIENTS: Oral Evaluations, Prophylaxis/Cleaning, Radiographs.

_____ I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/ or advisable by the doctor responsible for my treatment.

_____ I fully disclosed all health problems, including but not limited to: heart conditions, high/low blood pressure, diabetes, need for antibiotics prior to dental treatment (due to prosthetic valves, joints or heart conditions), medications taken/prescribed, bleeding problems, and allergies.

If you are receiving dental treatment other than an exam, dental cleaning and radiographs, please read and initial beside the Description of Treatment/Procedure(s):

_____**For Oral Surgery:** The extraction of a tooth is an irreversible process and whether routine or difficult, it is a surgical procedure. In any surgery, there are some risks. These risks include, but are not limited to, the possibility of pain or discomfort during and after the following treatment, swelling, infection, bruising, dry socket (due to dislodged blood clot), bleeding, injury to adjacent teeth (especially with large fillings, decay or crowns) and surrounding tissue, TMJ disorder, limited jaw opening of or displacement of a tooth or portion thereof into the sinus (especially with upper back teeth) or other anatomic location requiring additional surgery (and possible referral to Oral Surgeon) to close the opening or recover the tooth structure, temporary or permanent numbness, jaw fracture and allergic reactions. In addition, the decision to leave a small piece of root in the jaw when its removal would require extensive surgery may be necessary. To avoid injury to vital structures such as nerves or the sinus, small root tips may be left in place. Sharp ridges, or bone splinters may form later at the edge of the socket and may require another surgery to smooth or remove. The usual and most frequent risks and complications occurring from the planned treatment have been explained to me and by signing this form, I consent to the extraction of the above tooth/teeth.

_____ **For Dentures and Partial Dentures:** I realize that full or partial dentures are artificial and the problems of wearing these appliances have been explained to me (including, but not limited to, looseness, soreness, and possible breakage). I realize the final opportunity to make changes in my new dentures (including shape, size, placement and color of the teeth) will be the "teeth in wax" try-in visit. I understand the appliance may need to be relined 3-15 months after fabrication and the cost for this is not included in the initial denture. There may be additional charges for denture/partial adjustments in the future.

_____ **For Crowns and Bridges:** I understand it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I will be wearing temporary crowns and will ensure that they are kept on the tooth until the definite crown/bridge is cemented. I will verify the shape, color and size at the first appointment as the crown will be ready to cement at the following appointment. Endodontic procedures (root canals) are sometimes necessary after the preparation for the crown; root canals are a separate procedure and you may need to see a specialist if a root canal is needed. For implant crowns, we are not responsible for the successful placement and guarantee of the implant as we did not perform the implant placement.

_____ **For Endodontic Treatment (Root Canal):** I realize there is no guarantee that root canal treatment will save my tooth, and that a complication can occur from the treatment that may necessitate the extraction of the tooth. Occasionally metal objects are cemented in the tooth or extend through the root, which may/may not necessarily affect the success of the treatment. I understand there is considerable risk of instrument separation during root canal treatment in which referral to an Endodontist may be necessary to evaluate the situation, complete root canal treatment and /or perform surgical procedures to increase the root canal success. I understand that occasionally additional surgical procedures may be necessary following root canal treatment, root canals may have to be retreated, referral to an Endodontist (Ex:complicated root canal anatomy, inability to locate canals, calcified canals) may be necessary. If a tooth fracture is present, it may not be visually detected but may lead to the loss of the tooth, even after a root canal is performed.

_____ **For Conscious Sedation:** I understand I am not to drive after taking medications for dental anxiety. In addition, I will not operate machinery for the remainder of the day. I am not allergic to benzodiazepines (Valium, Triazolam, Versed, Ativan, etc.), pregnant or breast feeding, nor do I have liver or kidney disease. I have not consumed alcoholic beverages in the past 12 hours, nor have I used illicit drugs. Side effects may include light-headedness, headache, dizziness, visual disturbances, amnesia, and nausea. In some people, such as smokers, oral sedative may not work as desired. On the way home, your seat in the car should be in the reclined position. When at home, lie down with your head slightly elevated. Someone should stay with you for the next several hours due to possible disorientation and possible injury from falling.

_____ **During the course of treatment**, complications may arise that may necessitate additional procedures or alter the proposed course of treatment. Such complications may include, but are not limited to, the need for a root canal and or extraction. I acknowledge the practice of dentistry is not an exact science and offers no guarantees. When administering anesthetic, there is a rare but unavoidable risk of possible nerve damage, paralysis and/or dysesthesia. These complications may be temporary or permanent.

C. SIGNATURES - : I have had sufficient opportunity to discuss the treatment plan, the benefits to be reasonably expected from this treatment, as well as the alternative approaches, including no treatment. All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed. I confirm I have read this form or it was read to me.

COUNSELING DENTIST/PROFESSIONAL: I have counseled this patient as to the nature of the proposed procedure(s), attendant risk involved, and expected results, as described above.

Signature of Counseling Dentist/Professional	**Date and Time**

PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, described above.

Signature of Patient or Legal Guardian	**Date and Time**
Signature of Witness	**Date and Time**