Gorgeous DENTAL SMILE

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INFORMED CONSENT FOR GENERAL DENTISTRY PROCEDURES

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the work to be done below, then read and sign the section at the bottom of the form.

☐ **EXAMINATION AND DIAGNOSTIC PROCEDURES**

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

(initials _____)

☐ **DRUGS AND MEDICATION**

I understand that antibiotics, analgesics and other medications may cause allergic reaction causing redness, swelling of tissues, pain, itching and vomiting, and/or anaphylactic shock. I understand that the administration of local anesthetics may result in temporary or permanent parasthesia (numbness) of involved teeth, tissues, and associated structures. 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. I accept these risks by consenting to the use of local anesthetics during my dental appointments. If I have a medical condition that necessitates antibiotic pre-medication before dental treatment, it is my responsibility to notify the dentist. I assume all responsibility for all medical consequences if the dental office is unaware of my need for pre-medication.

(initials _____)

☐ **CHANGES IN TREATMENT PLAN**

I understand that my treatment plan is only an estimate and subject to modification/changes depending on unforeseen or un-diagnosable circumstances that may arise during the course of treatment. I understand that any alterations to treatment may affect the total cost of my treatment and accept responsibility for any and all expenses regardless of third party involvement.

(initials _____)

☐ **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. I understand a more extensive filling than that originally diagnosed may be required due to additional decay or tooth defect discovered during the preparation of the filling. This may result in a fee increase for which I accept financial responsibility. I accept that significant sensitivity is a common effect of a newly placed filling, which may necessitate further treatment in the form of bite adjustment, crown and or root canal therapy in the future. I realize that extremely large fillings may require a crown to prevent future breakage.

(initials _____)

☐ **REMOVAL OF TEETH**

Alternatives and consequences for tooth extractions have been explained to me. And I authorize the Dentist to remove the following teeth _____. I understand that removing teeth does not always remove all infection and it may be necessary to have further treatment. I accept the risks involved when having teeth removed, including pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time. I understand that I may require additional treatment with a specialist if complications arise during or following treatment, the cost of which is my responsibility.

(initials _____)

☐ **WHITENING**

I understand that there is a range within which teeth can be lightened and that some teeth respond better to the whitening process than others. I understand that my teeth may become more sensitive after treatment and fluoride gel and/or time usually alleviate this. The whitening information sheet and application instructions were explained to me. I understand that I will be given ___ tubes initially and responsible for buying additional tubes for $_____ per tube.

(initials _____)

☐ **PERIODONTAL TREATMENT**

I understand that I have a serious condition causing gum inflammation and/or bone loss and that if left untreated can progress and can lead to further jaw bone destruction and loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(initials _____)

☐ **ENDODONTIC TREATMENT (ROOT CANAL)**

I realize that there is no guarantee that root canal treatment will "save" my tooth, and that complications may occur from the treatment, and that occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment, but may cause parethesia (numbness). I understand that endodontic files and reamers are very fine instruments and stress vented in their manufacture can cause them to separate (break) during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. I understand that the tooth will require a crown after the root canal is completed, if it is not already crowned.

(initials _____)

 CROWNS BRIDGES AND VENEERS:

I understand that sometimes it is not possible to match the color of natural teeth exactly with the artificial teeth. I understand that I am responsible for approval of the appearance prior to permanent placement. I further understand that I will be wearing temporary crown, which may come off easily and that I must be careful to ensure that it is kept on until the permanent crown is placed. . I will be given the opportunity to view my crowns, bridges and veneers as processed, either on models or in place in my mouth prior to final cementation. I realize the final opportunity to make changes in my new crown, bridges and d veneers (including shape, fit, size and color) will be prior to cementation. It is also my responsibility to return for permanent cementation within 30 days from the tooth preparation. Excessive delays may allow for tooth movement in which a new crown, bridge or veneer may have to be remade. In this case, I the patient shall incur and take full responsibility for any additional charges. I understand porcelain crowns may fracture and that crowns bridges and veneers can come off, especially if chewing sticky foods. . I also understand that if crown, veneers and bridges has been repaired or serviced by other practitioner/dentist, PBS A Dental Corporation will not be liable for whatever problem may occur. I further understand that removing cemented crowns or veneers may create the risk of injury or breakage to the underlying teeth. I acknowledge that while a crown, bridge or veneer does not necessitate the need for a root canal, there may be a future need in which the dentist cannot foresee.

(initials _____)

 DENTURES – COMPLETE OR PARTIAL:

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size placement and color) will be the "teeth in wax" try-in visit. 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.

(initials _____)

 INSURANCE AND PAYMENT AUTHORIZATION:

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot properly guarantee results. I acknowledge than no guarantee or assurance has been made by anyone regarding the dental treatment that I have authorized. I hereby authorize the doctors and staff members to proceed with and perform dental treatment as explained to me.

- I UNDERSTAND AND AGREE THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL DENTAL EXPENSES INCURRED AT PBS A DENTAL CORPORATION.
- I UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE COMPANY AND MYSELF. AS A COURTESY, PBS A DENTAL CORPORATION WILL SUBMIT CLAIMS ON MY BEHALF TO MY INSURANCE COMPANY. REGARDLESS OF ANY THIRD PARTY OR INSURANCE INVOLVEMENT, I AM RESPONSIBLE FOR PAYMENT OF ALL DENTAL FEES.
- I UNDERSTAND THAT IF MY DENTAL INSURANCE CHANGES IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE
- I AGREE TO PAY ALL ATTORNEY'S FEES, COLLECTION FEES, OR COURT COSTS THAT MAY BE INCURRED TO SATISFY THIS OBLIGATION.
- UNFINISHED TREATMENT: I UNDERSTAND THAT IF I ELECT TO DISCONTINUE TREATMENT AFTER IT HAS BEEN INITIATED, PRO RATA PAYMENT MUST BE MADE FOR PROFESSIONAL SERVICES TO THAT POINT. REFUNDS ARE NOT APPLICABLE TO RESTORATIONS AND PROSTHESIS. (refer to CALIFORNIA CIVIL CODE 1793.02 SEC. e-3).

CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks including those as listed above. The fee(s) for service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. Precilyn Silvestre to render any treatment necessary and/or advisable to my dental conditions including the prescribing and administering any medications and/or anesthetics deemed necessary to my treatment.

PROCEDURE TO BE PERFORMED:

_____

_____

PATIENT'S SIGNATURE & DATE : _____

PATIENT'S PRINTED NAME : _____

PARENT/LEGAL GUARDIAN (if minor) : _____

WITNESS TO SIGNATURE : _____