DENTAL PRACTICE INFORMED CONSENT

I consent to the providers of EAHHC performing the dental procedures documented on my (my child's) **Treatment Plan dated** _____ which I have signed. I understand that the purpose and benefit of this treatment plan is to treat diseased oral tissues, improve the function of my teeth, enhance my smile, and/or improve my general health.

Procedures, Benefits, Risks and Alternatives

_____**Radiographs (X-rays):** X-rays have been recommended to aid in the diagnosis of dental problems that cannot be found by other dental examinations. The risk of radiation from dental x-rays is minimal. I understand that if I refuse to receive recommended x-rays, the doctor may elect not to treat me.

_____ **I authorize x-ray procedures to be performed as recommended.**

_____ **I do not authorize x-ray procedures to be performed as recommended.**

_____ **Drugs/Medications**: Local anesthesia has been recommended to help prevent discomfort during dental treatment. Complications from local anesthesia may include bruising, numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue that may last for several weeks, months, or in rare instances, be permanent. Nitrous oxide (laughing gas) may be recommended to relax you during treatment. I understand that any drug/medication can cause allergic reactions. These reactions include, but are not limited to, redness and swelling, pain, itching, nausea, vomiting, and in very rare instances shock that can lead to death. I understand that if I am told to take medications, it is my responsibility to take them as directed. I understand that I must inform the doctor immediately of any change in my health or any reactions to medications. I further understand that depending on my current medications, my risk for an allergic reaction may be greater.

_____ **I authorize the use of local anesthesia, nitrous oxide, and/or other drugs as deemed necessary.**

_____ **I do not authorize the use of local anesthesia, nitrous oxide, and/or other drugs as deemed necessary**

_____ **Preventive Services**: Preventive services have been recommended to prevent or treat gum disease, clean the teeth, eliminate mouth odors, and prevent cavities. I understand that complications from preventive services (cleanings and other treatments) may include, but not be limited to, pain, bleeding, trauma to gums, receding gums, tooth sensitivity to cold temperature or foods, swelling, ulceration, infection, tooth fracture, damage to other teeth and/or restorations (fillings). Reactions to fluoride treatment may include nausea or vomiting. I understand that a plastic material (sealants) may be applied to the chewing surfaces of back teeth to help prevent cavities, and they may have to be redone periodically. I understand that if space maintainers are used to prevent tooth movement, they must be monitored routinely. The alternative to preventive services is to do nothing. I understand that doing nothing may result in infection, tooth decay, tooth loss or other dental and/or health problems.

_____ **I authorize preventive procedures to be performed.**

_____ **I do not authorize preventive procedures to be performed.**

_____ **Periodontal Therapy/Scaling and Root Planing**: Periodontal therapy has been recommended to treat gum disease, remove plaque, tarter, and other deposits, and to decrease gum inflammation. I understand that complications from this treatment may include, but not be limited to pain, bleeding, trauma to oral tissues, receding gums, teeth appearing longer, changes in my speech, tooth sensitivity to cold temperature or food, food getting caught between teeth, exposure of crown (cap) margins, swelling, ulceration, cracking or bruising of mouth and/or lips, jaw

joint problems, infection, tooth fracture, damage to other teeth and/or restorations (fillings). Reactions to fluoride treatment may include nausea or vomiting. I understand that a follow up examination must be performed, and that additional treatment may be necessary if my gum disease is still present. I also understand that regular cleanings and examinations will be necessary to keep my gums healthy. The alternative to periodontal therapy is to do nothing. I understand that doing nothing may result in infection, tooth loss or other dental and/or health problems.

_____ **I authorize periodontal therapy procedures to be performed**

_____ **I do not authorize periodontal therapy procedures to be performed**

_____ **Extractions**: Extractions have been recommended to eliminate pain and/or infection or to remove teeth that cannot be repaired. I understand that the complications from removal of teeth may include, but not limited to pain, postoperative discomfort, swelling, restricted mouth opening that lasts for several days or weeks, prolonged bleeding, infection, damage to other teeth and/or "fillings", dry socket, aspiration of tooth, cracking and bruising of the corners of the mouth, decision to leave a small piece of root in the jaw when removal would require extensive surgery, opening into the sinus or nose, need for additional surgery, prolonged drowsiness, change in occlusion (bite) or jaw joint pain, fracture of the jaw, injury to a nerve, and numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue that may last for several weeks, months, or in rare instances, be permanent. Alternatives to removal of teeth may include root canal therapy, crown and bridge procedures, periodontal therapy, or doing nothing. I understand that doing nothing may result in continued or increased pain, swelling, infection or other dental and/or health problems.

_____ **I authorize extraction procedures to be performed**

_____ **I do not authorize extraction procedures to be performed**

_____ **Root Canal Therapy/Pulpotomy**: Root canal therapy has been recommended to relieve pain, infection, and/or save teeth. I understand that there is no guarantee that root canal therapy will save my tooth. Root canal filling material may extend through the root, which does not necessarily affect the success of the treatment. I understand that additional procedures may be necessary following root canal therapy (treatment or a surgical procedure). I understand that the tooth may be lost, regardless of all efforts to save it. Complications of treatment may include, but not be limited to pain, swelling, limited jaw opening that may persist for several days, breakage of an instrument within the root canal during treatment, opening of the side of the root from within the canal, damage to nerves that can cause tingling of the lip, chin, or other areas of the jaw or face, and fracture of the tooth during treatment. I understand that even when the treatment is successful, the tooth may fracture at a later date. I understand that once treatment has begun, it is essential that it be completed in a timely manner to avoid the need for further treatment, additional fees, and/or loss of the tooth. This includes the placement of a filling and/or permanent crown. I understand that I should expect a permanent crown on back teeth. Alternatives to root canal therapy include extractions of teeth and doing nothing. I understand that doing nothing may result in tooth loss, infection, or other dental and/or health problems.

_____ **I authorize root canal therapy procedures to be performed**

_____ **I do not authorize root canal therapy procedures to be performed**

_____ **Amalgams/Composites**: "Fillings" have been recommended to eliminate decay, relieve pain, fill a space, and/or improve your smile or bite. I understand that it may not be possible to match a tooth colored filling to the exact color of my natural teeth. I understand that complications associated with these procedures may include, but not be limited to pain, sensitivity to temperature, fracture of tooth, nerve damage, damage to other teeth, changes in my bite, and/or jaw joint complications. I understand that a more extensive procedure, such as root canal therapy or extraction may be necessary if/when advanced decay is discovered during the procedure. I understand that discomfort from sensitivity can be significant following the placement of a new filling. Alternatives to permanent fillings include temporary fillings and doing nothing. I understand that doing nothing may result in infection, advanced tooth decay, tooth fracture, tooth loss, bite problems, and other dental and/or health problems.

_____ **I authorize "filling" procedures to be performed**

_____ **I do not authorize "filling" procedures to be performed**

_____ **Inlays/ Onlays/ Crowns/ Bridges/ Veneers**: Inlays, onlays, crowns, bridges, and/or veneers have been recommended to improve your smile/bite, repair a tooth, or replace missing teeth. I understand that it may not be possible to match inlays, onlays, crowns, bridges or veneers to the exact color of my natural teeth. I further understand that I may be wearing temporary crowns or other temporary restorations, which may come off easily. If/when a temporary restoration comes off, I understand that I must return in a timely manner to have it replaced. I understand that excessive delays in placing the permanent restoration may result in tooth movement that could make a remake necessary. I understand that there will be additional fees for remakes that are a result of my delaying placement of permanent restoration. I understand that teeth with extensive fillings, structural damage and/or weakened tooth structure may not survive planned restorative treatment (fillings, crowns, etc.). These teeth may require more extensive treatment than originally planned or may even be lost if they are non-restorable. I understand that I may experience pain, sensitivity to temperature, fracture of the tooth, damage to other teeth, nerve damage, changes in my bite, and/or jaw joint complications as the result of these procedures. Alternatives to inlays, onlays, crowns, bridges, and/or veneers include temporary fillings, extractions, implants, dentures and partials or doing nothing. I understand that doing nothing may result in infection, tooth loss, bite or jaw problems, and/or other dental and/or health problems.

_____ **I authorize inlays, onlays, crowns, bridges, and/or veneer procedures to be performed**

_____ **I do not authorize inlays, onlays, crowns, bridges, and/or veneer procedures to be performed**

_____ **Dentures/Partials**: Dentures and/or partials have been recommended to improve your smile/bite and to replace missing teeth. I understand that every attempt will be made to satisfy my desires related to the appearance and function of my denture/partial, but there is no guarantee that the desired results can be achieved. I understand that I will have the opportunity to give my opinion about the appearance of my denture before final processing. I understand that a denture and/or partial may be difficult for me to wear and that it may not be due to the quality of the care. Complications may include, but not limited to, sore spots, changes in my speech, and difficulty eating. I understand that dentures/partials may require adjusting and/or relining. I have been advised that I may be charged for any adjustments beyond three, and that reline fees are not included in the price of dentures. The alternatives to dentures and/or partials include bridges, implants, and doing nothing. I understand that doing nothing may result in bite or jaw joint problems, or other dental and/or health problems.

_____ **I authorize denture and/or partial procedures to be performed**

_____ **I do not authorize denture and/or partial procedures to be performed**

_____ **Treatment Assistance:** Treatment assistance has been recommended to gain cooperation, eliminate disruptive behavior, or prevent injury. These procedures may include telling and/or showing the patient what is to be done, praising the patient for desirable behavior, getting the attention of the patient by changing the tone or volume of the provider's voice, placing a device in the mouth to prevent a patient from closing or biting, or holding the patient's hand, upper body, legs or head to prevent injury. The provider may ask for assistance from a parent/guardian during these procedures. The alternative to treatment assistance may include sedation or not treating the patient. I understand that if I elect not to authorize treatment assistance procedures, the doctor may determine that it would not be safe to treat me/my child.

_____ **I authorize treatment assistance procedures to be performed**

_____ **I do not authorize treatment assistance procedures to be performed**

_____ **Protective Stabilization**: The use of devices like a "papoose board" has been recommended to limit movement that could cause injury to a patient or provider. The patient is placed on a flat board and wide fabric straps are wrapped around the body. The alternatives to protective stabilization may include sedation or not treating the patient. I understand that if I elect not to authorize protective stabilization, the doctor may determine that it would not be safe to treat my child.

_____ **I authorize protective stabilization procedures to be performed**

_____ **I do not authorize protective stabilization procedures to be performed**

OTHER IMPORTANT CONSIDERATIONS
I understand that even when routine dental care is performed appropriately, it may cause or aggravate a TMD (jaw joint) condition.

I have been advised that if I discontinue care before treatment is completed, my present oral condition may get worse. The risks to my health may include, but are not limited to swelling, pain, infection, cyst formation, periodontal (gum) disease, tooth decay, problems with my bite, loss of teeth, and/or other risks to my general health.

I have been advised that no guarantee can be given that my treatment will cure my dental problems or be successful to my complete satisfaction for a guaranteed period of time. I understand that poor oral hygiene, irregular dental "cleanings", poor diet, medications/drugs, tobacco use, and certain health conditions are some factors that may result in a greater risk that my treatment will fail. I understand that my condition may relapse or get worse despite the care provided. However, it is the doctor's opinion that the planned treatment would be helpful, and that my condition may get worse sooner without the recommended treatment. I also understand that there will be a greater risk that my treatment will fail if I don't follow home care instructions and receive regular examinations and "cleanings" as recommended.

I understand that this treatment will be performed over a period of time requiring multiple appointments. If any other condition should arise in the course of my treatment, calling for procedures in addition to or different from those now known, I understand that the doctor will inform me of those procedures.

I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND/OR HAVE HAD THIS CONSENT EXPLAINED TO ME BY AN INTERPRETER, AND HAVE HAD MY QUESTIONS ANSWERED. I FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE CONSENT AND/OR ANY EXPLANATION(S) MADE.

_____ _____
Patient/Guardian Signature Date

_____ _____
Provider Signature Date

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