Matt Nashed, D.D.S. Name_____

Informed Consent

1. Work to Be Done

I understand that I am having the following work done: Examination and X-Rays_____, Fillings____, Bridges____, Crowns_____, Extraction____, Impacted Teeth Removed____, General Anesthesia____, Root Canals_____, Dentures_____, Partials_____, Root Planning/ Irrigation_____, Sealants_____, Surgical Up righting_____, Frenectomy_____, Operculectomy_____.

2. Drugs and Medications

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

3. Change in Treatment Plan

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give permission to the dentist to make those changes as necessary. Initial_____

4. Removal of Teeth

Alternative 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 under paragraph #3. I understand removing teeth does not always remove all the infection, if present if may be necessary to have further treatment. I understand that the potential risks of the procedure/surgery include but are not limited to: **A.** Post-operative discomfort, swelling, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage (possibly exposing crown margins), spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. **B.** Limitation of opening, stiffness of facial and or neck muscles, change in bite or temporomandibular joint (jaw joint) difficulty. **C.** Residual root fragments that may require extensive surgery or risk surgical complications may be left in place. **D.** Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery. **G.** Injury to the nerve underlying the teeth, resulting in itching, numbers, or burning of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, or months, or in some cases, permanently. Initial_____

5. Local Anesthesia

I understand that with the use of local anesthesia there may be the possibility of soreness/ sensitivity of gum tissue, hematoma or paresthesua. I also understand it is my responsibility to inform the dentist if I am having problems during or following treatment so as to allow him to minimize any problems. Initial_____

6. Nitrous Oxide

Nitrous Oxide may be recommended and accepted treatment by me. Possible side effects include upset stomach, dizziness and alteration of mood. I understand it is my responsibility to inform the dentist if I am having any of these or other side effects to him minimize any problem. Initial_____

7. Crowns, Bridges, and Caps

I understand that sometimes it is impossible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crown are delivered. I realize the final

Opportunity to make changes in my new crown, bridge, or onlay, (including shape, fit size and color will be before cementation. It is also my responsibility to return for permanent cementation with 3 weeks from tooth preparation. Excessive delays may result in tooth movement. This may necessitate the remake of the crown, bridge, or onlay. I understand there will be additional changes for remakes due to my delaying permanent cementation. In case of extreme sensitivity, endodontics may be performed. Initial_____

8. Dentures: Complete or Partial
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage and relining due to tissue change. Initial_____

9. Endodontic Treatment (Root Canal)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from treatment and that occasionally root canal filling materials may extend through the root, part of a file breaks off or separate inside the canal which does not necessarily affect the success of the treatment. 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.
Initial_____

10. Periodontal Treatment (Tissue and Bone)
I understand that I have a gum condition (moderate to advance periodontitis) involving inflammation of gum that may lead to gum and/or bone loss, tooth looseness & eventual loss of teeth. I also understand that Scaling & Root Planning together with better home care may improve the condition. I am aware that I may get gum recession & teeth sensitivity that could be associated with the treatment. Initial_____

I,_____, hereby request and authorize the dentists, their staff, and anesthetist to perform dental work upon me/my child for the purpose of attempting to improve my appearance, function and the health of my or my child's mouth, teeth, bone and tissues, as explained above
The effect and nature of the proceeding to be performed and the risk involved as well as the possible alternative methods of treatment have been fully explained to me. I also authorize the dentist, assistants, and anesthetist to perform any other procedure which they may deem necessary or desirable in attempting to improve the conditions that may be encountered during the procedure. I consent, authorize and request the administration of such anesthetics as are deemed suitable by the dentist/anesthetist if treatment is to be done with a local anesthetic. Initial_____

I know that the practice of dentistry and surgery is not an exact science and that therefore reputable practitioners can not properly guarantee result. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized. Alternative and possible untoward reactions have been explained to me in detail and clearly. Complication, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drug before, during and after surgery, numbness or itching of the tongue, lips, teeth, tissue (paresthesia) and fractured jaw, etc. have been clearly explained to me.
I certify that I have read and fully understand the above consent to dental treatment and that the explanations therein referred to were made. Anything I did not understand has been explained to me.

Signature:_____ Date_____
Patient or Legal Representative
Relationship_____
Witness_____