LASER DENTISTRY

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General Dentistry Information Consent

Name _____

1. DRUGS AND MEDICATION

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

2. 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 all/any changes and additions as necessary. (Initials _____)

3. REMOVAL OF TEETH

I understand that 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 (Paresthesia) that can last for an indefinite period of time (days or months) 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. Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery etc.)
(Initials _____)

4. CROWNS AND BRIDGES

I understand that sometimes it not possible 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 crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be before cementation. (Initials _____)

5. DENTURES – COMPLETE OR PARTIAL

I understand that full or partial dentures are artificial constructed of plastic, metal and/or porcelain. The problems of wearing these appliances including looseness, soreness, and possible breakage have been explained to me. I understand the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. I also understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee.
(Initials_____)

6. ENDODONTIC TREATMENT (ROOT CANAL)

There is no guarantee that Root Canal Treatment will save my tooth and complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extended through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following the root canal treatment (apicoectomy).
(Initials _____)

7. PERIODONTAL LOSS (TISSUE & BONE)

I understand that periodontal disease is a serious condition causing gum and bone inflammation or loss and it can lead to the loss of my teeth. Alternative treatment plans including gum surgery, replacements and/or extractions have been explained to me. Undertaking some dental procedures could have future adverse effect on periodontal conditions. (Initials _____)

I understand that Dentistry is not an exact science and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Signature_____ Date _____

Doctor _____ Witness _____