DeKamore Dental

PATIENT CONSENT FORM

In reading and signing this form, it is understood that ENGLISH is the language that I understand and use to communicate. DRUGS, MEDICATION AND ANESTHESIA: I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest. I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four [24] hours after my release from surgery). I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia and/or irritation to the area I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloral hydrate, "Xanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation and that someone needs to watch me closely for a period of 8 to 10 hrs. (Initials) П 2. ORAL HYGIENE I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits. (Initials) PERIODONTICS (TISSUE AND BONE LOSS) I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction. (Initials) 4. **REMOVAL OF TEETH:** I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time. Potential risks include, but are not limited to, the following: A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e., surgery. Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area. C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty possibly requiring physical therapy or surgery). D. Residual root fragments or bone spicules left when complete removal should require extensive surgery or needless surgical complications. E. Possible bone fracture which may require wiring or surgical treatment. 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, numbness, or burning sensation of the lip, chin, gums, cheek, teeth, and/or tongue or pain in the jaw on the operated side; this may persist for several weeks, months, or in remote instances, permanently. I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility. (Initials)_____ FILLINGS: I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and as such is a treatment used by Universal Care. The advantages and disadvantages of alternate materials.

CROWN AND BRIDGE (CAPS): 6.

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

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(Initials)_____

	Signature of Doctor	Dr. No.
Signature	e of Patient or Legal Representative	Relationship to Patient Date
COOPEI AND HA BASED	RATION AND EXPLANATION REFER AVE HAD THEM ANSWERED TO MY S I UNDERSTAND THAT UNIVERSAL CAR	RE DENTAL PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION L ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY
RECOMN RESULT	MENDATIONS OF THE DOCTOR WHILE IN LESS THAN OPTIMUM RESULTS. I CERTIFY THAT I HAVE HAD AN (PLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD DEPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND THE TERMS AND THE TERMS AND THE TERMS AND
		OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE
does not g	so away area a surrecent period of time.	(Initials)
A. B. C. D. E. F.	Parent/guardian Cooperation - Unless the cremain in the waiting room while the child is Positive Reinforcement - Rewarding the child objects or toys. Voice Control - The attention of a disruptive Hand-Over-Mouth Exercise - The disruptive the dentist speaks directly into the child's ear stops the hand is removed and the child is pexercise repeated. At no time is the airway eventual Physical Restraint - Restraining the child's of the dentist's or assistant's hand or arm, or by understand Oral Seda is administered through a breathing mask. Oral cat or drink for a period of four hours prior to child home after the sedation procedure, and of understand that with the use of an injection	d who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or toker child is gained by changing the tone or increasing the volume of the doctor's voice. It is child is told that a hand is to be placed over the child's mouth. When the hand is in place and tells the child that if the disruptive noise stops the hand will be removed. When the noise raised for cooperating. If the noise resumes the hand again is placed on the mouth and the restricted. It is increased to the property of a special device (referred to as a "papoose board"). It ion - Nitrous Oxide is a mild gas that is mixed with oxygen, and used to sedate a person. It is sedation medications are administered to children to help them relax. The child should not the Nitrous Oxide sedation appointment. The parent/guardian must be available to escort the
	e 1	FORM: used at Universal Care Dental Services, as well as being accepted procedures in the denta
	-	(Initials)
and finish the treatm I un	n final root canal therapy. If root canal treatment may have to be redone, root-end surgery may	treatment area. Edure is performed, I understand that this is not permanent treatment, and I need to pay for at is not finalized I expose myself to infection and/or tooth loss. If root canal therapy fails ay be required, or the tooth may have to be extracted. The months following nerve treatment of a "baby tooth" for evaluation, and the possibility
E.	Perforation of the root canal with instrumextraction.	nents, which may require additional surgical treatment or result in premature tooth loss of
A. B. C. D.	Post treatment discomfort lasting a few hours Post treatment swelling of the gum area in the Infection and/or restricted jaw opening.	ent risks can include, but are not limited to the following: to several days for which medication will be prescribed if deemed necessary. e vicinity of the treatment tooth or facial swelling, may persist several days or longer. attment, which may in the judgment of the doctor be left in the treatment root canal as part of the removal.
	8. ENDODONTIC TREATMENT (R The purpose and method of root canal ther	OOT CANAL THERAPY): apy have been explained to me, as well as reasonable alternative treatments, and the
properly f	fitted. I also understand that due to bone loss or	other complicating factors, I may never be able to wear dentures to my satisfaction. (Initials)
change. I immediate	Follow-up appointments are an integral part ely examined by the doctor. I further understand that surgical intervention	of maintenance and success of a prosthetic appliance. Persistent sore spots should be (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for dentures to be
	7. DENTURES - COMPLETE OR PA	ARTIAL: blained to me including looseness, soreness, and possible breakage, and relining due to tissue