General Dental Consent Form

Patient Name	Last	First	Middle Initial	Date of Birth

1. Exam, X-Rays, and Cleaning:

   I understand that the initial visit will require radiographs in order to complete the examination, diagnosis, and treatment plan. If I do not have any periodontal concerns, a preventive ("regular") cleaning will be performed. If the dentist can not adequately perform my initial examination due to excessive calculus (tartar), or I am diagnosed with Periodontal disease, I understand that treatment will not initially be a preventive ("regular") cleaning. I understand that treatment may involve multiple visits in a short period of time to properly treat my condition. I will be given a "best" estimate of fees to properly treat my condition before treatment is performed.

2. Drugs, medications, and sedation:

   I have been informed and understand that antibiotics, analgesics, and other medications can cause redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and agree to not operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of prescribed analgesic or sedative medications. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. 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 teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures, or the need for a pulp cap during the restorative procedure. I give permission to the Dentist to make any or all changes and additions as necessary.

4. Temporomandibular Joint Dysfunction (TMD):

   I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joint subsequent to routine dental treatment wherein the mouth is held in the open position for an extended period of time. However, symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is the responsibility of the patient.

5. Fillings:

   I understand that care must be exercised in chewing on filling material during the first 24 hours to avoid breakage, and tooth sensitivity is common after a newly placed restoration.

6. Removal of Teeth (Extractions):

   If an extraction is needed, a separate consent form will be given explaining any possible complications. I will be informed of my options for replacing any missing teeth (implants, bridges, or removable prosthesis).

7. Periodontal Treatment:

   I understand that if diagnosed with Periodontal disease, I have a serious condition causing gum inflammation and/or bone loss and that it can lead to loss of my teeth. I also understand that success of treatment depends, in part, on my efforts to brush and floss daily, receive maintenance cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations.

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8. Patient Responsibility for Max Benefits & Non-Covered Services:

   Dental insurance does not typically pay for all of your dental costs. Some services are not considered "covered benefits" under your dental insurance plan and will not be paid for. Your dental insurance plan may also have "limited coverage" per calendar year or only pay a certain amount per year (Max Benefits). The patient will be responsible for all costs associated with non-covered dental services.

Consent:

I understand that dentistry is not an exact science, therefore: reputable clinicians cannot properly guarantee results. Results rely heavily on my active role in maintaining proper oral health. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment that I request and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist, other than the treating Dentist, is responsible for my dental treatment. I may refuse any treatment that is proposed but must inform the Dentist prior to work being performed.

_____	_____	_____
SIGNATURE of Patient or Patient's Representative	PRINTED NAME of Patient or Patient's Representative	DATE