THE SZIKMAN DENTAL GROUP, P.C. GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME _____

*** PLEASE NOTE:** This is an all-purpose consent form. Actual procedures will be treatment planned and discussed with each patient accordingly.

1. TREATMENT TO BE PERFORMED
I understand that I will be receiving an examination that includes a sufficient number of dental X-rays that may be necessary to complete my examination and any additional community-appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if my dentist deems the need for a referral to a specialist necessary, then any costs of this referral that are not covered by dental insurance would be my responsibility. (Initials_____)

2. DRUGS AND MEDICATIONS
I understand that antibiotics, analgesics and other medications can cause allergic reactions manifesting clinical symptoms such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (a severe allergic reaction). I understand that it is my responsibility to inform my dentist of any allergies to specific medications to avoid possible adverse effects from medication that my dentist will prescribe. (Initials_____)

LOCAL ANESTHETICS
The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in the heart rate; however, it will return to normal shortly thereafter. Common complications that can occur from local anesthetic (but are not limited to) are pain, swelling and bruising. Rare serious complications may occur that can include (but are not limited to) permanent numbness, abnormal sensation, transient blindness, and even death.
(Initials_____)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment, it may be necessary to change or add procedures due to 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 any/all changes and additions as necessary once I have been informed of these changes and have consented to them. I also understand that by not following my dentist's recommendation, delayed treatment can lead to but not limited to more discomfort, increase the complexity of the treatment outcome, or eventual loss of teeth. (Initials_____)

4. EXTRACTIONS (REMOVAL OF TEETH)
I give my consent for the doctor to perform the extraction/oral surgery to treat and possibly correct my diseased oral tissue, or other procedures deemed necessary or advisable as necessary to complete the planned operation/extraction. If left untreated, the risks to my health may include (but are not limited to) swelling, pain, infection, cyst formation, gum diseases, dental decay, malocclusion, and premature loss of teeth and/or bone. My dentist has informed me of possible alternative methods of treatment.
Potential risks include, but are not limited to the following:

A. Post-operative discomfort; stretching of the corners of the mouth, with resultant cracking and bruising; 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.
B. Injury to adjacent teeth, prosthesis, and/or restorations that may require additional treatment 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 tempromandibular jaw joint; difficulty possibly requiring physical therapy or surgery.
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone and/or jaw fracture, or opening of the maxillary sinus requiring additional surgery.
F. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue, which may be temporary or permanent.

If any unforeseen condition should arise in the course of the operation/extraction 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 he may deem advisable, including referral to another dentist or specialist. (Initials_____)

5. CROWNS AND BRIDGEWORK
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns or bridgework, which may come off easily and could be aspirated, and I must be careful to ensure that they are kept on until the permanent crowns or bridgework are delivered. I understand that if my temporary crowns or bridgework come off, then it is my responsibility to return to my dentist to have them re-cemented. I realize that the final opportunity to make changes in my new crowns or bridgework including shape, fit, size and color will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crowns or bridgework, they may not fit properly and I will be responsible for any lab fees. (Initials_____)

(TURN OVER, PLEASE)