River City Dentistry, PC (Jason Allred, DMD)

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General Dentistry Informed Consent

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

☐ **1. Changes In Treatment Plan:**
I understand that during the treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. I give my permission to the Dentist to make any/all changes and additions as deemed necessary.

☐ **2. Removal of Teeth:**
Alternatives to removal of tooth/teeth have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the treatment planned teeth and any others necessary for reasons in paragraph #1. I understand that the extraction of teeth does not always completely removed the infections that is 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, and surrounding tissues (Paraesthesia) that can last for an indefinite period of time. I understand I may need further treatment by a specialist if complications arise during the following treatment, the cost of which Is my responsibility.

☐ **3. Fillings:**
I understand that care must be exercised in chewing on fillings especially the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

☐ **4. Endodontic Treatment (Root Canals):**
I realize there is no guarantee that tooth canal treatment will save my tooth and that complications can occur from the treatment and that occasionally root canal fillings may be slightly short of the root tip or it may extend beyond the root tip which does not necessarily effect the success of the treatment. I understand that occasionally addition surgical procedures may be necessary following root canal treatment (apiceotomy). I understand that the tooth may be lost despite all efforts to save it.

☐ **5. Periodontal Disease (Loss of Bone and Tissue):**
I understand that I have serious condition involving both my gums and supporting bone and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum and bone surgery, replacements and/or extractions. I understand that any dental procedures may have a further adverse effect on my periodontal condition.

☐ **6. Crowns and Bridges:**
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 a temporary restoration which may come off easily and that I must be careful to ensure that they are keep on until the permanent crowns are cemented in place. I realize the final opportunity to make changes in my new crown, bridges, or caps (including shape, fit, size and color)will be before the final cementation. It will be my responsibility to return for permanent cementation within 30 days from the tooth preparation. Excessive delay may allow for tooth movement. This may necessitate a remake of the crown, bridges or caps. I understand that there will be additional charges for remakes due to my delaying permanent cementation.

☐ **7. Drugs and Medication:**
I understand that antibiotics and other medications can cause allergic reactions. This can result in redness and swelling of tissues, pain, itching vomiting, and/or anaphylactic shock. (For women) I understand that taking antibiotics may render any birth control medications I am taking ineffective.

☐ **I understand 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. 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 is responsible for my treatment. I hereby authorize Dr. Schau and her dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this Is only an estimate and is subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fee, collection fees or court costs that may be incurred to satisfy this obligation. I have read, understood and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this assignment.**

Signature _____ **Date** _____

Response Date: _____