Association of Vietnamese American Dentists

INFORMED CONSENT FOR DENTAL TREATMENT

PATIENT: _____

ALL PATIENTS INITIAL 1 THRU 5 BELOW, AND 6 THRU 14 AS NEEDED. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

_____2. TREATMENT

I understand I am having the following dental treatment performed:

Fillings Crowns Bridges Dentures Extractions
Scaling & Root Planing Root Canals Other

_____3. DRUGS, MEDICATIONS AND SEDATION

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment for my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

_____4. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgement to provide appropriate care.

_____5. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking, and pain can intensify or develop in the joint in the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although 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, the cost of which is my responsibility.

_____6. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional conditions discovered during preparation. I understand that sensitivity is a common after effect of a newly placed filling. I understand that significant changes in response to temperature may occur after tooth restoration. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I realize that fillings are rarely “permanent” and usually require periodic replacement.

_____7. CROWNS, BRIDGES, VENEERS AND BONDING

_____A. 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, which are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size, color, etc.) will be before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation. I understand I may need further treatment by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

_____B. I am electing to follow the Dentist’s recommendation of using high noble instead of base metal in my crown and bridge restorations.

_____C. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

_____8. DENTURES

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not “permanent.” Sore spots, altered speech and difficulty eating are common problems. I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable at first. Immediate dentures require frequent adjustment and one or more relines within several months. A permanent reline or a second set of dentures will be necessary later. The cost for this procedure is not included in the initial denture fee. I realize 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 understand that failure to keep appointments may result in a less desirable result. I understand that it is my responsibility to return for delivery of dentures. If a remake is required due to my delay of more than 30 days, additional fees may be incurred.

_____9. EXTRACTIONS

Alternatives to tooth removal have been explained to me (root canal therapy, crowns, extensive restoration, periodontal (gum) treatment, etc.). It is my understanding that the following teeth will be removed _____

I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I have been told that the risks of removing teeth include, but are not limited to: pain, swelling, infection, dry socket, exposed sinuses, fracture of bone or jaw, and loss of feeling in my lips and/or other facial areas, cheek, tongue, gums and teeth. Such numbness (paresthesia) may be temporary or permanent. I understand that further care by a specialist or even hospitalization may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

_____10. PERIODONTAL DISEASE

I understand that I have periodontal disease, a serious condition causing gum inflammation and/or bone loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including non-surgical (deep) cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care (brush and floss daily, follow a healthy diet, avoid tobacco products) and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that periodontal disease may have future adverse effect on the long-term success of dental restorative work. I understand that care by a specialist may be necessary.

_____11. ROOT CANAL THERAPY

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from treatment. Occasionally the canal filling material may extend through the end of the root, which may or may not affect the success of treatment, and which may require additional treatment. I understand that occasionally additional surgical procedures (apicoectomy) may be necessary to complete therapy. I understand that root canal files and reamers are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I also understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. I understand that the tooth may be lost despite the best efforts to save it.

_____12. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours of treatment. I understand I may experience sensitivity of the teeth after treatment and/or gum inflammation, which will subside when treatment is discontinued. The Dentist may prescribe fluoride treatments for rare cases of persistent sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

_____13. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness, and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

_____14. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

_____15. OTHER

_____

_____

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated laboratory fees are my financial responsibility.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Doctor's Signature Date

_____

Witness' Signature Date