General Informed consent

1. Work to be done: I understand that I am having any or all of the following work done: Fillings, Bridges, Crowns, X-rays, Extractions, Root Canals, Dentures or any other work the dentist deems necessary.
Patient initials _____

2. Drugs and medications: I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise my dentist of any medications I am taking prior to starting dental work may have unforeseen negative consequences for me.
Patient initials _____

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 the teeth that were not discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. These changes will be discussed with me and I will have the opportunity to verbally agree or decline the change in treatment, unless it is not practical due to a dental/medical emergency.
Patient initials _____

4. Removal of teeth: Alternatives to removal will be explained to me (root canal therapy, crowns, periodontal surgery, etc.), and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved with extraction, some of which are pain, swelling, spread of infection, dry socket, and loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can be temporary or permanent, and fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.
Patient initials _____

5. Crowns, bridges and caps: 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 may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit, and color) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 21 days from initial tooth preparation. Excessive delays may allow for tooth movement or additional decay which may necessitate a remake of the crown, bridge, or cap. In such instances, I understand that there will be additional charges for remakes due to my delaying permanent cementation.
Patient initials _____

6. Endodontic treatment (root canal): I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to break in my tooth during treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy), or the root canal may be short or have other complications and may need to be redone. My root might also be perforated during the procedure causing me to lose the tooth. I understand that the tooth may be lost in spite of all efforts to save it and that a root canal is not a guarantee the tooth will be saved.
Patient initials _____

7. Periodontal loss (tissue and bone): I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that any dental procedure may have a future adverse effect on my periodontal condition.
Patient initials _____

8. Fillings: To avoid breakage, I understand that care must be taken when chewing on fillings, especially during the first 24 hours. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that increased sensitivity is a common effect of a newly placed filling.
Patient initials _____

9. Dentures: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of 30 days or more, there may be additional charges assessed against me.
Patient initials _____

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.
I hereby authorize any of the doctors or dental assistants or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

"Advance Community Health is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at <http://www.ochin.org> www.ochin.org. As a business associate of Advance Community Health, OCHIN supplies information technology and related services to Advance Community Health and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Advance Community Health with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement."

_____ _____
Patient signature/legally authorized representative Date

_____ _____
Relationship Date

_____
Printed name if signed on behalf of the patient