Santa Monica Orthodontics
Love Your Smile!

GENERAL DENTISTRY INFORMED CONSENT

1. WORK TO BE DONE
I understand that I am receiving the following treatments: Fillings _____, Bridges_____, Crowns _____,

Extractions _____ , Root Canal_____ , Exams & X-Ray_____ , Other _____ .

Initials _____

2. DRUGS, MEDICATIONS, AND SEDATION
I have been informed and understand that allergic reactions can result from the use of antibiotics, analgesics and other medication, including redness and swelling, pain, itching, vomiting and/or anaphylactic shock. Such medications can also cause thrombophlebitis (vein inflammation) from intravenous and intramuscular injections, and stiffening of and/or injury to the neck and face muscles. They may cause drowsiness and impaired awareness and/or coordination, which may be aggravated by alcohol or other drug use. I understand and fully agree to not operate a vehicle or other potentially hazardous device for a period of at least 12 hours, or until fully recovered from the influence and effect of any anesthetic, medication, or drugs received in the office during my care. I understand that failure to take medication in the amount and manner prescribed may risk continued or aggravated infection, pain and resistance to effective treatment. I understand that on occasion I might experience paraesthesia (prolonged but temporary numbness) of the lower lip or tongue after an injection of local anesthetic.

Initials _____

3. CHANGE IN TREATMENT PLAN
I understand that, during the course of treatment, changes or additions to some or all of the initial procedures may be made if new conditions are found in the teeth or gums that were not manifest during initial examination, the most common of these being root canal therapy following routine restorative procedures. I give my full permission to the Dentist to make any and all changes and additions as necessary.

Initials _____

4. REMOVAL OF TEETH
Alternatives to tooth removal have been explained to me (including root canal therapy, dental crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth, as well as any others found necessary for the reasons in paragraph 3. I understand that tooth removal does not necessarily remove infection that may be present, and that further treatment may be needed. I understand the risks associated with tooth removal, which include pain; swelling; spread of infection; dry socket; and indefinite loss of feeling (paraesthesia) in teeth, lips, tongue and surrounding tissue; and jaw fracture. I understand further specialist treatment or hospitalization may be needed if complications arise during or after treatment, the cost of which is my responsibility.

Initials _____

5. CROWNS, BRIDGES, CAPS, VENEERS AND BONDING
I understand that it is not always possible for artificial teeth to match the color of natural teeth exactly. I also understand that I may be wearing temporary crowns, which may come off easily, and that I have responsibility to keep them in place until permanent crowns are placed. I acknowledge that the final opportunity to make alterations in my new crown, bridge, cap or veneer (including shape, size, fit and color) will be prior to cementation. It has been explained to me that, in exceptional cases, cosmetic procedures may result in the need for root canal treatment, which cannot always be predicted or expected.

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I understand that cosmetic procedures may have an effect on tooth surfaces and may require alteration in my daily oral hygiene procedures.

Initials _____

6. DENTURES (COMPLETE OR PARTIAL)
I realize that full or partial dentures are artificial and created from plastic, metal and/or porcelain materials. Potential issues stemming from their use have been explained to me, including looseness, soreness and possible breakage. I understand that the final opportunity to make alterations in my new denture(s) (including shape, size, fit and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to 12 months following placement, and that the cost for this procedure is not included in the initial fee.

Initials _____

7. ENDODONTIC TREATMENT (ROOT CANAL)
I understand that there is no guarantee that root canal treatment will save my tooth, that complications can arise from treatment, and that occasionally small metal objects may be cemented into the tooth or extended through the root, which does not necessarily affect the success of treatment. I understand that additional surgical procedures, such as apicoectormy, may be necessary following root canal treatment.

Initials _____

8. PERIODONTAL LOSS (TISSUE AND BONE)
I understand that I have a serious condition that causes gum and bone inflammation and/or loss which can result in the loss of my teeth. Alternative treatment options such as gum surgery, tooth replacement and/or tooth extraction have been explained to me, and I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initials _____

I understand that dentistry is not an exact science, and therefore that reputable practitioners cannot guarantee any specific results. I acknowledge that no guarantee or assurance has been made by anyone regarding my 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 provided me. I also recognize that no dentist other than the treating dentist is responsible for my treatment. I understand and acknowledge the receipt of post-operative instructions, and have been given a day for return appointment.

Signature: _____ Date: ___/___/_____
Doctor: _____ Witness: _____