Smile LA Dental

3. INFORMED CONSENT - Smile LA Dental

Patient's name: PATIENT, NAME Chart#:1

1. DRUGS AND MEDICATIONS

Antibiotics, analgesics, and other medications may be required for and/or following treatment. Allergic reactions including redness and swelling of tissue, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction) may occur.

2. ANESTHESIA

I realize the risks involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness. The instructions, expectations, and precautions have been explained.

3. FILLINGS - COMPOSITE AND AMALGAM

Amalgam "silver" fillings are utilized primarily for restoring posterior teeth. Composite or "tooth colored" fillings are primarily used when restoring anterior teeth. I understand that the dentist will determine the most appropriate material for restoring the tooth. I may request the restoration material of my choice for personal, cosmetic, and/or health reasons, etc. I will be responsible for payment of treatment that is not a covered benefit of my insurance.

4. REMOVAL OF TEETH - EXTRACTION

Alternatives to removal have been explained - Root canal, crown, periodontal surgery, etc. Extracting teeth does not always remove all of the infection and further treatment may be necessary. Some risks involved: pain, swelling, spread of infection, dry socket, fractured jaw or parasthesia (the usually temporary but possibly permanent numbness and/or tingling in the teeth, lips, tongue, and/or surrounding tissue). I may require treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

5. ENDODONTICS (ROOT CANAL) AND EMERGENCY PALLIATIVE TREATMENT

There is no guarantee that root canal therapy will save my tooth and complications can occur from the treatment. Occasionally additional surgical procedures may be necessary following root canal therapy (apicoectomy, root amputation) No warranty or guarantee of success has been or can be given for endodontic therapy. This treatment may require multiple visits and I can cause serious damage or I can loose the tooth if i do not complete the prescribed treatment.

6. CROWNS, BRIDGES, AND VENEERS

Sometimes it is not possible to match the exact tooth color of natural teeth with artificial teeth. I may be wearing temporary crowns, which may come off easily and I must be careful until the permanent crowns are delivered. Final opportunity to make changes in my new crown, bridge, cap- including shape, fit, size, color - will be determined before cementation. Any changes after cementation will be at my expense. If I don't have the permanent restoration placed permanent serious damage or loss of the tooth/teeth involved may occur, and if I delay placement I may cause the teeth involved to move so that permanent crown no longer will fit properly.

7. PERIODONTAL DISEASES (TISSUE AND BONE)

This is a serious condition causing gum inflammation and/or bone loss and can lead to the loss of teeth. Alternative treatment plans have been explained, including gum surgery, implants, and/or extractions.

8. DENTURE - FULL OR PARTIAL

Full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The possible complications have been explained to me including looseness, soreness, and possible breakage. Final opportunity to make changes in my new denture - including shape, fit, size, placement, and color - will be during the teeth try-in visit. Most dentures require relining due to tissue and bone change during the first 12 months after initial placement. The cost for this procedure is not included in the initial denture fee.

9. CHANGES IN TREATMENT PLAN

It may be necessary to change or add procedures during the course of treatment. Any changes will be presented and discussed with the patient or legal guardian prior to treatment.

I understand that dentistry is not an exact science. No warranty or guarantee of success has been or can be given regarding the dental treatment which I have requested and authorized.

3. INFORMED CONSENT - Smile LA Dental

I hereby request and authorize the dentists, and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance , function and health of my mouth, teeth, bone and tissues, as explained above. The effect and nature of the procedures to be performed, and the risks involved, as well as possible alternative methods of treatment have been fully informed to me. I certify that I have read and fully understand the above consent to dental treatment and that the explanations therein referred to were made. Anything I did not understand has been explained to me.

Patient/Responsible Party Name	Signature	Date

Provider	Witness