SAN MARCOS DENTAL STUDIO

GENERAL DENTISTRY INFORMED CONSENT

Dentist: Dr. Babak Shahrokh Patient:_____

1. WORK TO BE DONE: I understand that I am having the following work done: Fillings( ), Bridges ( ), Crown ( ), X-rays ( ), Extractions ( ) , Impacted teeth removed ( ), Root Canals ( ), Dentures ( ), Other_____. (Initials _____)

2. DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain itching, vomiting, and/or anaphylactic shock. (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 discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. (Initials _____)

4. REMOVAL OF TEETH: Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) And I authorize the dentist to remove the following teeth:_____ and any others necessary for reasons in paragraph #3. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infections, dry socket, loss of feeling in my teeth , lips tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time or 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. (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 crown bridge or cap (Including shape, fit and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remake due to my delaying permanent cementation. (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 effect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. (Initials _____)

7. PERIODONTAL LOSS (TISSUE AND BONE): I understand that I have a serious condition, casing gum and bone inflammation or loss and that it can 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 undertaking any dental procedure may have a further adverse effect on my periodontal condition. (Initials _____)

8. FILLINGS: I understand that care must be exercising in chewing on fillings especially during 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 common after effect of a newly placed filling. (Initials _____)

9. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (Placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is no 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 delays of 30 days, there will be additional charges. (Initials _____)

I understand that dentistry is not an exact science and that 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 herby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatment as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen and un-diagnosable 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 an attorney's fees, or court cost, that may be incurred to satisfy this obligation.

Signature of Patient _____ Date:_____

Signature of Dentist _____ Date:_____