**Informed Consent** Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please do not initial or sign this until it is discussed with the dentist. As the dentist discusses the items below with you, please initial indicating you acknowledge the item has been discussed and then sign the bottom.

**General**

\_\_\_\_\_I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days;

\_\_\_\_\_That I may have bleeding, pain, swelling, and discomfort for several days and that it’s possible I may develop an infection after receiving treatment that must be treated with antibiotics or other procedures.

**Anesthesia**

\_\_\_\_\_I understand that I will receive a local anesthetic to numb my mouth. In rare cases, patients have a reaction to the numbing agent, which may need emergency medical attention, or find that it affects their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment (such as filling material, small pieces of tooth, etc.);

\_\_\_\_\_That it is normal for the numbness to take time to wear off, usually 2 - 3 hours. In some cases, it can take longer and in some rare cases, the numbness can be permanent.

**Extractions**

\_\_\_\_\_I understand that the necessary blood clot that forms where the tooth was removed may break down or come out and that it can be painful lasting a week or more and I will need to see a dentist to have it treated;

\_\_\_\_\_That the instruments used in extracting a tooth may accidently chip or damage teeth next to the one being worked on, which could require further treatment to restore their appearance or function;

\_\_\_\_\_That upper teeth have roots that may be close to the sinuses. Removing these teeth may temporarily leave a small opening into the sinuses. Antibiotics or additional procedures may be needed to help close this opening and prevent infection;

\_\_\_\_\_That pulling a tooth may cause the surrounding bone to fracture. Sometimes, the tooth to be extracted may be stuck to the surrounding bone. Pieces of bone may arise at the site and are usually easy to remove;

\_\_\_\_\_That the nerves that control feeling in my teeth, gums, tongue, lips and chin run through my jaw and sometimes it may be impossibleto avoid touching, moving, stretching, bruising, cutting or injuring a nerve. This could change the normal feeling in any of these areas, causing itching, tingling, burning, numbness, or the loss of all sensation including loss of taste. These changes could last from several weeks to several months or in some cases permanently.

**Fillings**

\_\_\_\_\_I understand fillings are placed to restore the tooth after removing the decay. If left untreated decay can cause pain, infection and eventual tooth loss;

\_\_\_\_\_That risks of receiving fillings include, but not limited to, sensitivity, tooth fracture and nerve sensitivity that may lead to the need for a root canal. I also understand that I need to be careful when chewing on fillings during the first 24 hours so the filling does not break.

**Root Canal**

\_\_\_\_\_I understand that problems that may occur include, but are not limited to: extra openings of the canal made by an instrument, blocked root canals that cannot be totally cleaned and filled, fracture, chipping, or loosening of existing tooth or crown requiring replacement, and temporary or permanent numbness or painful nerve sensations;

\_\_\_\_\_Teeth that have received a root canal may become brittle and crack or break over time;

\_\_\_\_\_In some cases, root canal treatment may not relieve all symptoms and I may need my tooth extracted.

**Dental Cleaning**

\_\_\_\_\_I understand a cleaning involves the removal of plaque and calculus above the gum line and that the treatment does not address gum infections below the gum line called periodontal disease.

\_\_\_\_\_That as a result of the treatment, some bleeding may occur;

\_\_\_\_\_That it is possible that a filling(s) could become loose or lost and may not be able to be replaced.

OVER

**Consequences if No Treatment is Administered, Not Limited to the Following:**

\_\_\_\_\_ I understand that if I do not receive treatment I may continue to have problems related to my dental condition(s), which could include pain and/or infection, loss of the bone surrounding my teeth, changes to my bite, pain in my jaw joint, and premature loss of other teeth.

\_\_\_\_\_ I have been given the opportunity to ask questions and I give my consent for treatment.

**Patient’s or Legal Guardian/Representative Signature**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that I have discussed the risks, benefits, consequences, and alternatives with this patient and he/she has had the opportunity to ask questions. I believe my patient understands what has been explained and willingly consents to the treatment herein.

**Dr.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes:**