FRISCO SQUARE DENTAL

Patient Information/Informed Consent

Treatment Plan. **I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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.**

Cancellation Policy: **I understand that in the event I miss or fail an appointment without a 24 hour notice, a $50 broken appointment fee will be billed to my account.**

Drugs and Medications. **I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swollen tissue, pain, vomiting, itching, and/or anaphylactic shock.**

Extractions. **Alternatives to removal of teeth have been explained to me (root canal therapy, crown and bridge procedures, periodontal therapy, etc.). I understand removing teeth does not always remove the infection, if present , and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, 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 of which is my responsibility.**

Crowns, Bridges, Veneers. **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 come off easily, and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape, fit, color, and size) will be before cementation. It is also my responsibility to return for permanent cementation within thirty (30) days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation.**

Endodontic Therapy. **I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may expand through the tooth, which does not necessarily effect the success fo the treatment. I understand that endodontic files and reamers are very fine instruments and that stresses and defects in their manufacture can cause them to separate during use. I understand that the tooth may be lost in spite of all efforts to restore it and that the alternative treatment of extraction has been explained to me. I further understand that delay of treatment or no treatment of this tooth could result in compromised results and/or complications to my overall health.**

Periodontal Disease. **I understand that I have been diagnosed with a serious condition, causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. Alternative treatments will be explained to me, including gum surgery, tooth extraction, and/or replacement.**

Fillings. **I understand that care must be exercised in chewing on filled teeth, especially during the first twenty-four (24) hours, to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decay. I understand that significant sensitivity is a common after-effect of newly placed fillings.**

Partials and Dentures. **I understand the wearing of partials/dentures is difficult. Sore spots, altered speech, and difficulty in eating are 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 at a later date. This is no included in the denture fee. I understand that it is my responsibility to return for delivery of my partial/denture. 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 more than thirty (30) days, additional charges could be incurred. I understand that dentistry in not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized.**

Patient _____ **Date**_____

Guardian signature: _____