General Dentistry Consent

Work to be Done
I understand that I may be having the following work done: Exam, X-rays, Prophy/Cleaning, and fillings. This consent will be valid indefinitely unless otherwise expressed in writing by the physician or the patient.

Changes in Treatment
I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during the examination. For example, root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions necessary.

Periodontal Cleaning/Scaling
I understand the most common complications are pain, bleeding, tissue (gum) laceration, sensitivity to temperature foods, swelling, ulceration (infection), tooth fracture, and/or breaking of fillings. Reactions to fluoride treatment may be nausea or vomiting.

Fillings
I understand that the most common complications are pain, sensitivity to temperature, fracture of tooth, nerve damage, damage to other teeth, occlusal (bite) discrepancies, TMP complications, reactions to drug and/or anesthesia. Sensitivity to hot and cold temperatures could last a long time after work is done. Most of the time it is just a few days. There could also be tenderness to bite and the bite may need to be adjusted.

The doctor has explained to me that there are certain inherent and potential risks in ANY treatment plan or procedure. We do not expect these to occur, but there is that possibility. In this specific instance such as risks include, but are not limited to the following:

A. Nerve inflammation leading to hot and cold sensitivity due to deep decay or excessive restoration.
B. The need for endodontic therapy (root canal)
C. Cracked cusp and/or fracture of the tooth or filling
D. A shorter length of serviceability of the restoration with the need for more frequent replacement.
E. In cases where the previous restorations (fillings) are very large, the use of cast or full coverage crowns, or bonded porcelain may be indicated.

Local Anesthetic
It has been explained to me that there are certain risks to having local anesthetic or (shots) with a needle. They include allergic reactions, electric shock or possible death. I understand there can be numbness in my lip, tongue or chin that can last several weeks or permanent in rare cases. Further I realize that is epinephrine is used it can cause heart flutter and acute anxiety. Local anesthetic can cause drooping of the eyelid and side of the face known as Bell's palsy effect. At the injection site there can be bruising, swelling or a hematoma. Additionally, muscle soreness can occur on or at the injection site that can last several days or more.

I understand that dentistry is not an exact science and therefor reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested or authorized.

I herby authorize Dr. Oltean, and her staff to proceed with and perform the dental procedures and treatments as had been explained to me. I understand this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during treatment. I understand that regardless of any insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collection fees, or court costs that me be incurred to satisfy this obligation.

Patients Name:_____

Patients Signature:_____ Date:_____