General Consent for Treatment

I consent to “dental treatment” by the doctors at Restoration Smiles, P.C. I understand that this includes my first visit and necessary or advisable intra/extra oral examination, radiographs (x-rays), intraoral photos, study models, cleaning of teeth, and fluoride application (for children under the age of 18). If I choose not to have x-rays and fluoride application (for children under the age of 18) performed during my routine visits, I will let my provider know before the start of every appointment. If x-rays are necessary for complete and accurate diagnosis and I refuse to have them taken, I understand that the doctors at Restoration Smiles, PC. may not be able to treat me and will refer to another provider.

In general terms, dental treatment may include but is not limited to one or a number of the following:

- Administration of local anesthesia.
- Cleaning of the teeth and application of topical fluoride.
- Scaling and root planing with local anesthesia.
- Application of sealants to the grooves of the teeth.
- Treatment of diseased or injured teeth with dental restorations. These restorations will be composite (white fillings).
- Stainless steel crowns for children. These are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities.
- The replacement of missing teeth with a dental prosthesis (crown, partials, etc.).
- Treatment of diseased or injured oral tissues (hard and/or soft).
- Treatment of malposed (crooked) teeth and/or developmental abnormalities.
- Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or root canal treatment/pulpotomy.
- Extraction of non-restorable teeth or abscessed teeth.

Risks of Dental Procedures in General: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation of a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects. Patients treated with certain medications for osteoporosis may experience problems with or necrosis of the jawbones. **Changes In Treatment Plan:** I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary. I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs. **Crown (Caps) And Bridges:** 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 understand that I must return for a permanent crown within a timely manner or my crown may not fit properly due to shifting of teeth. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit size, and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge.

Alternative Treatment: I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care. By signing below, I consent to the general dental treatments and/or proposed treatment.

Medical Consultation: It may become necessary for the dentist to speak with other dentist/ medical providers who have attended to me. Permission is given to speak with other providers as needed for management of my case.