ELITE FAMILY DENTAL
GENERAL DENTISTRY INFORMED CONSENT

Dentist: **Elite Family Dental** Patient:_____ (print name)

1. WORK TO BE PERFORMED

I understand Dentist will/may perform the following procedures on Patient (check all applicable:

[ ] Fillings;
[ ] Crowns;
[ ] Bridges;
[ ] Extractions;
[ ] Impacted Teeth Removed;
[ ] Dentures
[ ] X-Rays;
[ ] Root Canals;
[ ] Dentures; and/or
[ ] Other (specify): _____

By **initialing** below I consent to the above-mentioned procedures and acknowledge that I have been fully informed of the dangers and risks associated with such procedures. _____

2. DRUGS AND MEDICATION

Antibiotics, analgesics, and other medications may cause allergic reactions which may lead to redness and swelling of tissue, pain, itching,vomiting, and /or anaphylactic shock. In the event that antibiotics, analgesics and other medications are necessary for the performance of procedures to which I consent, I acknowledge that I have been informed of the dangers and risks associated with such antibiotics, analgesics, and other medications. _____

3. CHANGES IN TREATMENT PLAN

During treatment it may be necessary to change or add procedures because of conditions found while working on the teeththat were not discovered during examination. For example root canal therapy may be required following routine restorative procedures. In the event changes or additions to the treatment plan become necessary, I give my permission and consent to Dentist to make any and all changes and additions as Dentist deems necessary. _____

4. REMOVAL OF TEETH

In the event tooth removal becomes necessary for my treatment, alternatives to removal of teeth have been explained to me (root canal therapy, crowns and periodontal surgery). In the event Dentist deems it necessary to remove teeth, I consent and authorize Dentist to remove any and all teeth as necessary, including those which become necessary pursuant to Section 3 above. I further acknowledge that I understand removing teeth does not always remove allinfections, if present, and further treatment may be necessary. I acknowledge and understand the risks associated withtooth removal, including without limitation pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia)which can last for an indefinite period of time, or fractured jaw. I understand that I may need further treatment by a specialist if complications ariseduring or following treatment, the cost of which is my responsibility. _____

5. CROWNS, BRIDGES AND CAPS

In the event crowns, bridges, and/or caps become necessary for my treatment, I understand that sometimes it is not possible to match the color of natural teeth with artificial teeth. I further understand that I may bewearing 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 acknowledge that the final opportunity to make changes in my new crown, bridge or cap (shape, fit, size, and color) will be before cementation. It is also my responsibility to return to Dentist for permanent cementation within twenty (20) days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. _____

6. ENDODONTIC TREATMENT (ROOT CANAL)

In the event that endodontic treatment (root canal) becomes necessary for my treatment, I have been informed and acknowledge that there is no guarantee root canal treatment will save my tooth, and that complications can occur from the treatment and that occasionally root canal fillingmaterial may extend through the tooth, which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in 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 despite all efforts to save it. _____

7. PERIODONTAL LOSS (TISSUE AND BONE)

In the event that I have a serious condition, causing gum and bone inflammation or loss, I understand and acknowledge that my condition may cause further inflammation or loss and may result in the loss of my teeth. I acknowledge that alternative treatment plans have been explained to my, including gum surgery, replacements, and/or extractions. I understand and acknowledge that any dental procedures performed on me may have adverse effects on my periodontal condition. _____

8. FILLINGS

In the event that fillings become necessary for my treatment, I understand and acknowledge that care must be exercised in chewing on fillings,particularly during the first twenty-four (24) hours of treatment, to avoid breakage or damage. I understand and acknowledge that amore extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have caused me pain prior to the filling being performed. _____

9. DENTURES

In the event dentures become necessary for my treatment, I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (i.e., placement of dentures after extractions) may be painful. Immediate dentures may require considerable adjusting and several realignments. A permanent realignment will be required. Realignments are required and are not included in the denture fee and must be paid for separately at such time. 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 delay of thirty (30) or more days, I understand and acknowledge that there will be additional charges. _____

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot guarantee results. I understand and acknowledge that no guarantee or assurance has been made by anyone regarding my dental treatment, to which treatment I have requested, authorized, and consented. I understand that, regardless of any dental insurance coverage I may have, I am responsible for payment of all dental fees.

In the event of non-payment by Patient, Patient agrees to pay all attorney fees, collection fees, and court costs that may be incurred by Dentist to satisfy Patient's payment obligation.

Patient: _____

Print Name: _____

Date: _____